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ORIGINAL ARTICLES.

WOMEN IN MEDICINE.*

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You have just received the degree of the oldest medical college for women in the world. Age is notoriously a test of the excellence of friends and wine, but is not necessarily a criterion of the standing of a medical school. Still, I think it will be found that the fittest of such institutions have survived, and it cannot be denied that a college which has steadily progressed for nearly fifty years, as regards its equipment, the character and scope of its instruction, and, above all, its facilities for clinical teaching, is entitled to a place among the foremost.

In this connection, I may allude to the question whether separate schools for the medical education of women are preferable to those in which students of both sexes are gathered together, and I will answer it by saying that it depends entirely upon the character of the school. The plant on North College Avenue has, through careful cultivation, flourished until now it may be compared to a tree as sturdy as the oak, as graceful as the cypress, whose leaves are for the healing of the nations. Is such a tree ever to be uprooted, transplanted, or grafted upon another? The fact that no such scheme has ever been distinctly formulated is no guarantee that none such will ever be broached. The integrity of your Alma Mater is in the hands of her alumnæ and I am confident that they will labor to preserve it. I am opposed to the multiplication of medical schools; I am in favor of consolidation, but of such a nature as to preserve the Woman's Medical College of Pennsylvania as the chief medical school in the world for women. The relations between the Woman's Medical College and the other medical schools of this city are, to my certain knowledge, of the most cordial nature; and how could they be otherwise when to all of them she stands *in loco sororis?* Long may she maintain this proud pre-eminence of sisterhood! An institution, like an individual, may merge her corporate identity with, become wedded to, one other, but she can be sister to a dozen.

On occasions like the present it is customary for the speaker to give the young graduate some parting words of advice, and I will endeavor to make mine both useful and palatable. The laws of supply and demand regulate the circulation of all commodities, not excepting that of advice.

* An address to the graduating class of the Woman's Medical College, delivered May 19, 1897.

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It was a wise man who said to one who asked him for counsel in some emergency: "Tell me what kind of advice you want and I will give it you." He well knew that unpalatable advice would neither be swallowed nor digested, much less assimilated. My position, however, is somewhat different. I do not regard myself as speaking to you as an individual, but as the mouthpiece of the Faculty who have been so confiding as to elect me to perform that function. I feel that I can give you a few words of advice with that confidence which arises from numerical support, for, as is well known, "in the multitude of counselors there is safety,"—at least for the counselors!

You have entered the ranks of a profession whose code of ethics is based upon the well-known Hippocratic oath, an instrument that antedates the Christian era, and is essentially based upon the Golden Rule. Kidd, in his remarkable book on social evolution, demonstrates, with almost mathematical accuracy, that the progress of mankind has been chiefly due to altruism, which, in its turn, is based upon religion. It is not my province to descant upon the comparative merits of the chief religions of the world. Suffice it to say that those which I have in mind have the common attribute of humanity. There is then a religion of humanity, and I believe its most genuine minister to be the physician. He lives, moves, and has his being in an atmosphere of humanity. I have known men of our profession who would have found it very difficult to formulate any religious belief, men whom many a Pharisee would have regarded as on the broad road to perdition, and yet men of whom it might truly be said, "they went about doing good."

Your opportunities for the exercise of charity will be endless. I do not refer to the most trivial exercise of this greatest of all virtues—the relief of pecuniary distress. The physician is, perhaps, of all men, the least able to indulge in such a pleasure, but, by way of compensation, he finds unusual scope for charity in thought, word and deed, and, as a rule, he avails himself of it. I must confess that he is not one who "thinketh no evil," for none is more conversant than he with the wickedness of mankind. In his solicitude for the sinner he is perhaps too lenient to the sin, and this is because he is dealing with concrete facts and troubles himself very little about abstractions. In extolling the virtues of charity, I do not mean to imply that its application is limited to the patients under your care. Its highest exercise is in relation to your fellow-practitioners. The physician in active practice is constantly being informed of the mistakes of his colleagues and is only too prone to contrast his own acumen with their stupidity, forgetting for the moment that the stories of mistaken diagnosis, neglect, brutality and malpractice are, nine times out of ten, absolutely false. I have been long enough engaged in the exercise of our calling to vouch for this fact and to warn you against giving credence to tales which redound to the disadvantage of your colleagues. It is so easy to coincide with the patient's criticism of one who had preceded you in the treatment of his case, either by your significant silence or by the faint praise which damns; and so difficult under such circumstances to give your hearty approval of what you know to have been well done. If it were not difficult, it would cease to be a virtue. I may say, with justifiable pride, that I have been favored with the friendship of some of the most eminent physicians, both men and women, of our day, and I can assure you that they have, as a rule, been distinguished by their reluctance to think evil of their fellows; in other words, by their large-hearted charity.

In the beginning of your practice you will undoubtedly be over-solicitous about the welfare of your patients. To the laymen of my audience this may seem impossible; for how, they may inquire, can a physician be too zealous in the performance of his duties, too anxious for the recovery of those intrusted to his care? The answer is evident, and will at once arise in the mind of the experienced practitioner.

If the excessive solicitude of the physician shows itself in unnecessary visits, visits made to observe the effect of remedies of whose actions he has had little practical experience, the patient will soon begin to agree with me that there is such

a thing as an excess of medical zeal. Ponder over your cases, lie awake at night for anxiety about them, provided you cannot sleep, talk them over with your medical friends, if they will listen to you, consult your authorities, but do not betray your anxiety to the patient. This advice is hard to follow at first, but, in the course of years, although a serious case will now and then cause you great anxiety, you will look back in amazement at the sleepless nights you passed and wonder how you could have been so foolish. The tendency, in time, is toward the opposite extreme—to indifference; and here let me repeat the advice, *mutatis mutandis*, which I have just given you. Be as indifferent as you please; do not let your most serious cases interfere with your appetite or digestion, or disturb your night's rest, but do not betray your indifference to your patients and, above all things, do not forget their names. There is no difficulty about the latter point in the early days of your practice. It is a very easy matter, at that time, to recall the names of the few who have done you the honor to consult you. They are, as it were, "graven with an iron pen," but as the years pass and patients multiply, you will find that the names of many of them are "writ in water."

Never argue with the laity on medical subjects. Tell them frankly that, for the sake of argument, or rather, to avoid argument, you are perfectly willing to admit that they know more by intuition about the anatomy and functions of the human system than you have learned by years of laborious study. That is one method of avoiding futile discussion with the ignorant, and one that I myself have practised with success. Another is what might be styled the modified Socratic method. For example, an old lady once asked me, in the innocence or deceitfulness of her heart: "Doctor, what is Bright's disease?" "Madam," I replied, "are you acquainted with the minute anatomy of the kidney?" She was horrified at the idea of such a thing and inclined to be offended until I pointed out that the recognition of morbid changes in an organ implies an acquaintance with its normal structure. What possible significance can such terms as coagulation necrosis, amyloid degeneration, or even fatty degeneration, have to the uninitiated? The clergyman and the lawyer will often dispute the diagnosis of the ablest physician, and yet how amazed, yea, how indignant, are they when their opinions, in matters connected with their own callings, are questioned. There is undoubtedly an attractiveness about the healing art that is possessed by no other. Every one would like to be a physician; a fact that is expressed in the proverb that at forty, a man is either a fool or a physicisn. What nonsense! If this proverb were true the number of fools would be incalculable, for it would not only include every non-medical man over forty, but a great many so-called physicians as well.

The physician should make it a rule never to talk about himself or his own affairs in the sick room, and, above all things, he should never complain of being tired or ill. No conjunction can be imagined more malignant than that of a sick patient and a sick doctor. Patients are not in the least interested in the ailments of their physician. There are exceptions to all rules, and I can recall the case of an old woman at the Philadelphia Hospital who never failed, when I visited her, to inquire most affectionately after my health; but it is only fair to add that she was suffering from senile dementia.

You are all undoubtedly anxious to succeed in the profession of your choice, but I wish to emphasize the fact that the most successful physician and the most famous is not necessarily he who accumulates the most money. True success is not to be gauged by any material standard. While I will not go so far as to say that the ability to make money is incompatible with true greatness, I will say that many of the greatest minds, whether in science, literature or art, have given little evidence of the possession of this money-making faculty. When I see a physician with the commercial instinct or faculty highly developed, I cannot help thinking,—no matter how successful he may appear in the world's eye,—this man has mistaken his calling; he should have been a tradesman.

I take it that success in life consists, not in the mere acquisition of property, but in the fullest development of our faculties,

mental, moral and spiritual, and this is only to be accomplished by activity. The proverb that a rolling stone gathers no moss is undoubtedly true, but, like many such trite sayings, it contains a certain element of fallacy. The question is whether moss is, after all, a desirable acquisition. It is very beautiful, very picturesque, but is also a parasitic accretion which must be removed before the stone can serve any useful purpose. Do not imagine that I am holding up the rolling stone as a model for your imitation. I am merely endeavoring to emphasize the fact that motion, even though it be passive, is, from a utilitarian standpoint, better than mere inertia. Besides, there is no greater pleasure in life than that derived from the efficient performance of congenial work. This is the testimony of all great thinkers. "If," said Mallebranche, "I held truth captive in my hand, I should open my hand and let it fly, in order that I might again pursue and capture it."

"Did the Almighty," said Lessing, "holding in his right hand Truth, and in his left Search after Truth, deign to offer me the one I might prefer, in all humility but without hesitation, I should request Search after Truth." The same thought has found poetic expression:

> "If what shone afar so grand
> Turn to nothing in thy hand,
> On again; the virtue lies
> In the struggle, not the prize."

I have thus far offered suggestions and advice that are applicable to physicians in general. Let me now say a few words to you as women. We hear a great deal nowadays about the "new woman," but let me remind you that it is nothing new for women to distinguish themselves in literature, science and art. Without quoting examples from classical literature I will call your attention to the remarkable revival of learning which took place under the generous patronage of Isabella of Spain. "The Queen's instructor in the Latin language was a lady named Dona Beatriz de Galindo, called from her peculiar attainments, La Latina. Another lady, Dona Lucia de Medrano, publicly lectured on the Latin classics in the University of Salamanca; and another, Dona Francisca de Lebrija, daughter of the historian of that name, filled the chair of rhetoric with applause at Alcala." A century earlier, Novella d'Andrea frequently supplied her father's place at the University at Bologna, and it is recorded by Christina of Pisa that her beauty was so striking that a curtain was drawn before her in order not to distract the attention of the students:

> "Drawn before her
> Lest if her charms were seen, the students
> Should let their young eyes wander o'er her,
> And quite forget their jurisprudence."

I need not multiply facts to prove that the new woman is centuries of years old.

You have doubtless, during your student career, encountered people who have expressed surprise that any woman could engage in such disgusting pursuits as anatomy and surgery. Permit me to furnish you with an answer to these critics. The qualifications of the surgeon are tersely described in a proverb which you will find at the head of one of the chapters of what many regard as Bulwer's best work.[1] "A good surgeon," says this proverb, "must have an eagle's eye, a lion's heart, and a lady's hand." Now all will acknowledge that one of these qualifications, the lady's hand is possessed by every graduate of our school, while the eye of the eagle is quite as likely to be the possession of woman as of man. There remains for our consideration the leonine heart. In all history, there is but one man to whom the epithet "lion-hearted" has been universally accorded, while, in my opinion, it might have been bestowed with equal propriety upon Joan of Arc, Elizabeth of England and Isabella of Spain.

In conclusion, let me assure you that the corporation whose seal is stamped upon your diplomas possesses a soul which will be cheered by your prosperity, and that the highest interests of your Alma Mater are in many respects identical with your own.

Four thousand seven hundred and sixteen kilogrammes of crude cocain were exported from Peru in 1894—a most astonishing amount. — *Meyer Brothers' Druggist.*

[1] What Will He Do With It? Book XII., Chap. II.

A CONTRIBUTION TO THE STUDY OF ANASTOMOSIS OF THE HOLLOW VISCERA—A MODIFIED MURPHY BUTTON.

JOHN S. MILLER, A.M., M.D.,* PHILADELPHIA.

Of all the time-saving devices for anastomosis of the bowel or of any of the hollow viscera, no more ingenious and useful means has been devised than the Murphy metallic button. While the results thus secured are vastly superior to those previously attained, yet current medical literature contains cases in which this apparatus did not satisfactorily accomplish its object. Briefly, the most serious objections to the Murphy button is the probability of retention, obstruction and gangrene. Its disadvantages consist in the introduction of a foreign non-absorbable body which practically occupies the intestinal caliber, and which is capable of causing disagreeable and even fatal results. Czerny,[1] of Heidelberg, has reported eleven cases in which he used the metallic button, of which three died from gangrene of the intestine. H. H. Clutton [2] has reported a case in which he removed a large dilated sigmoid flexure, and united the two ends of the divided bowel with a Murphy button. The operation was perfectly successful, but some months later the patient began to suffer from increasing symptoms of obstruction. On median celiotomy the small intestine was found collapsed and empty, but the

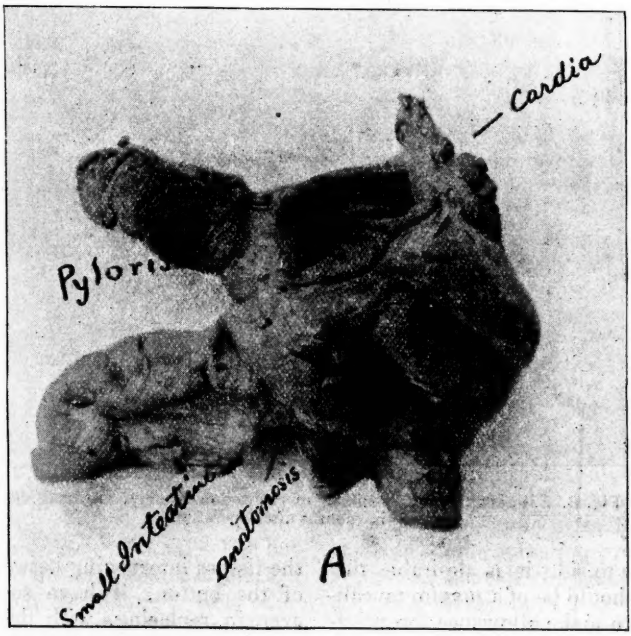

Fig. A. Exterior view of specimen of gastro-enterostomy. Animal destroyed on the 27th day, for the purpose of securing specimens.

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[1] Transactions German Medical Congress, August, 1896.

[2] Transactions Royal Medical Society. *The Medical Week*, October, 1896.

large intestine was enormously distended with liquid feces and practically filled the abdomen. The button was found high up in the splenic flexure, and could not be dislodged. The surgeon finally cut down upon it, and took it away. He further states that this is by no means the first time that the Murphy button has traveled upwards. Murphy attributes this peculiarity to the surgeon putting the wrong end, *i. e.*, the heavy end, upwards.

In all forms of anastomosis, either end to end or side to side, it is desirable that the aperture should be of a maximum caliber in order to make allowance for possible future contraction. This latter undesirable result is quite common, and no one method has succeeded in overcoming it entirely. The metallic button, therefore, must be of a size consistent with the caliber of the bowel to be operated upon. Consequently the use of such a device is sometimes attended with the same danger as would be due to an enterolith or other rounded closely-fitting foreign body. The immediate usefulness of the button is ideal; its after-effects only can be objected to. Therefore, if this button or a similar contrivance were made of a material which, after accomplishing its real object or function, would be digested or macerated, this objection would be removed.

An ideal button should efficiently do the primary work as well as a metallic one, yet should be absorbed sufficiently early after firm union of the parts, and thus avoid the dangers alluded to. With this object in view I have endeavored to devise a completely absorbable button, but I have found it mechanically impossible to secure in such a device the all-important "pressure atrophy" or necrosis of the tissues intervening between the halves of the button. I have succeeded, however, in replacing, with decalcified bone, all of the metal of the Murphy button except the pressure-spring and the central ratchet cylinder. When this modified button has fulfilled its mission, the bulk of the foreign body to be passed through the intestinal canal is diminished to one-quarter and the weight to one-fifth.

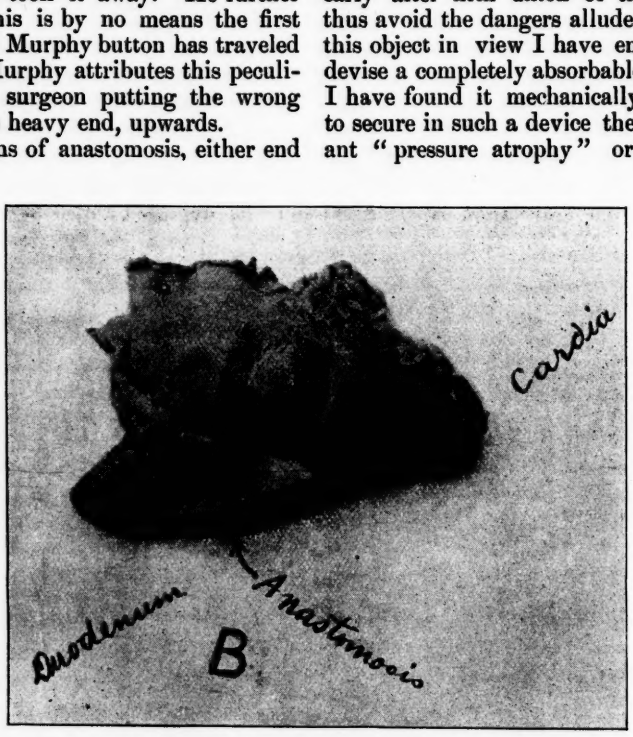

Fig. B. Exterior view of specimen of gastro-enterostomy. Animal destroyed six months after operation.

I first exhibited such a completed button at a meeting of the James Aitken Meigs Medical Association, March 15, 1896. On the following day with its aid I performed gastro-enterostomy on a dog, and at the subsequent monthly meeting of the society I exhibited the specimen showing firm union of the parts, and also the

cylinder and spring which had been passed after nine days. No trace of the button proper could be found. Czerny[3] predicted the possibility that a button capable of being absorbed would yet be found. I have no wish to create the impression that the result of my work is all that can be desired; but if I succeed in stimulating others to follow up and improve upon this line of research I shall feel myself amply rewarded. It may be stated here that such a line of investigation is expensive, consumes much time and requires more patience.

That the subject of intestinal anastomosis is still unsettled, is proved by the plenteous devices that have been advocated within recent years. All exhibit some degree of ingenuity and excellence. Apart from the success or failure in this line of experimentation, the technic developed and the dexterity acquired are of inestimable value to the surgeon in abdominal operations.

Preparation of Bone Button.—The buttons are turned out of a compact block of bone taken from the femur or tibia of an ox. They form cups of which the walls are a scant one-eighth of an inch thick. These are perforated for the admission of the male and female cylinders. Two notches are cut into each button to receive the flanges of the cylinders to make firm and hold the parts together, thus forming one of the varieties of a bayonet joint. (See Fig. I, E.) The metallic parts of this button, viz., the cylinders, are identical with those of the Murphy button, and therefore need no no other description. (See Fig. I, F, G, H.) The pressure-ring is made of bone and is flanged. (Fig. I, C.) Its function is the same as that of the metallic ring in the Murphy button.

Decalcification.—The metallic parts of the button are removed and the process of decalcification is conducted as suggested by Senn.[4] The cups or buttons are immersed in a ten per cent. solution of hydrochloric acid, the fluid being changed every twenty-four hours until they have become sufficiently soft. After decalcification they are washed in running water for five or six hours. The buttons to be used in operations on the stomach should be decalcified to the extent of about fifty per cent.; those for intestinal work should be completely decalcified. The gastric juice would prematurely digest a fully decalcified button, and thus defeat the object of the operation. The intestinal juices do not act so vigorously, and the hardening process to which the fully decalcified bones are afterwards subjected guards against absorption before permanent union will have taken place. To make an accurate estimate of the degree or depth of the softening process, I placed a plate of bone of the same thickness as the walls of the button in the fluid with the buttons, and by daily cutting off a piece it could readily determine how far the decalcification had progressed. For hardening and preserving, the buttons may be placed either in Müller's fluid, alcohol, or formalin solution, two per cent. I prefer the last. Senn, in his experiments with bone-plates, used partially decalcified bones in gastro-enterostomies, and fully decalcified ones in intestinal operations. In none of my experiments have I found the remains of the partly decalcified portion of the buttons, complete absorption having taken place after the button had fulfilled

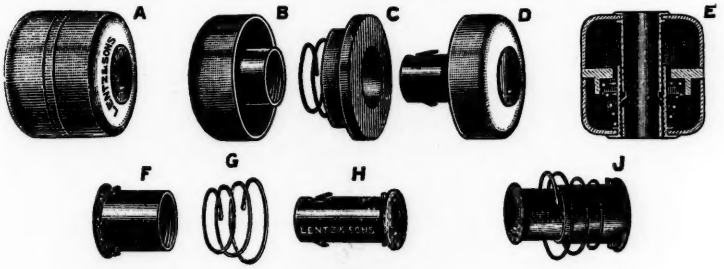

FIG. I.

[3] *Satellite*, October, '96.

[4] Intestinal Surgery, N. Senn, p. 179.

its work. In several instances the spiral pressure spring came away independently and was soon followed by the telescoped cylinders. To avoid irritation or perforation of the bowel the free end of the spring is provided with a little bulb of solder.

The buttons are made in three sizes. Fig. I A, shows a button approximated.

B, C, D, represent the component parts separated. B is the female portion, and C and D brought together form the male part of the button. E represents a vertical section of the button approximated. F, G, and H are the only metallic parts of mucus and food may obstruct the cylinder, and thus cause intestinal obstruction. The weight of the dog should be from fifty to seventy pounds, and it should not be too fat. Even in comparatively lean dogs the omentum is frequently very fat and it requires a longer incision and considerable delay and manipulation to secure the viscera to be operated upon.

Preparation of the Animal.—Beginning three days before the operation, daily doses of one ounce of castor oil should be given to promote free evacuation from the bowels. Liquid food only should be permitted.

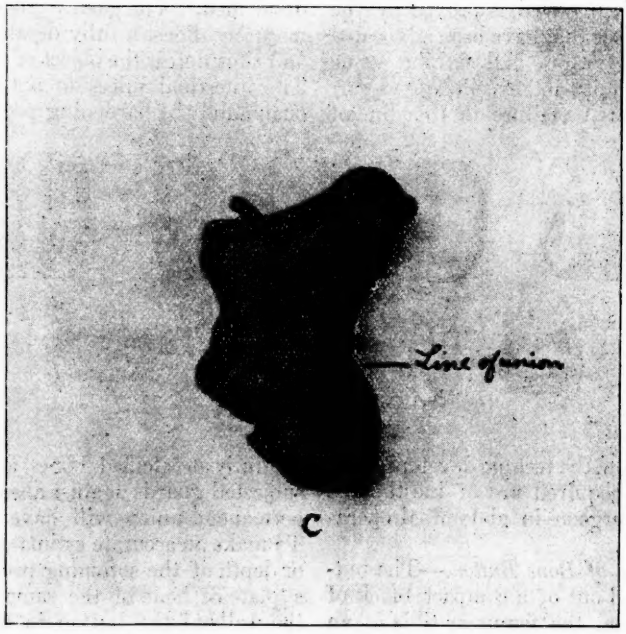

Fig. C. Exterior view of intestinal end-to-end approximation two months after operation.

the button. J represents these as they are discharged with the feces.

Selection of Dogs.—If possible, the animals should be females, since in them the range of the incision may be anywhere from the ensiform cartilage to the symphysis pubis, while in the male it is limited to within an inch of the penis. This organ and its function interfere with the maintenance of an aseptic or even an antiseptic dressing. Short-haired animals are the more desirable, as the stomach and intestines frequently contain great masses of hair, and in long-haired animals hair,

Anesthesia.—The A. C. E. mixture has been highly recommended by veterinarians in operations on the lower animals. This anestheti was used in my early experiments, and in some cases the animals came alarmingly near perishing. I substituted ether, and found that it acted very satisfactorily. After etherization the belly is shaved over an area of six inches by eight inches, and the long hairs beyond are clipped. The parts are then thoroughly scrubbed with green soap and washed off with ether, followed by mercuric chlorid solution, 1 to 1000. The animal is covered

with a large piece of sterilized muslin with a slit in the center and four perforations for the legs. The preparation of the instruments, ligatures, sponges, etc., should be in strict accordance with the rules governing asepsis. I have found, however, that the extreme precautions applied in human surgery are not necessary in operations on the dog. The peritoneum in this animal does not seem to be very susceptible to the influence of microbes. The diet and the habits of the dog appear to make the intestine was simply divided with a pair of scissors. The assistant holds the intestinal ends between the thumb and index fingers, which constitutes the best form of clamp. If the animal is well prepared the intestinal canal is usually empty. Frequently, long intestinal worms are found, and must be removed before the button is introduced. The Murphy running thread (purse-string) is then inserted loosely into the ends of the divided gut. Either of the segments of the button is

Fig. D. Exterior view of intestinal end-to-end approximation four and one-half months after operation.

him in a measure proof against surgical infection. In spaying female dogs veterinary surgeons ordinarily pay very little attention to asepsis, and the mortality from peritonitis is very slight.

Technic.—The median incision may be two to three inches long. The omentum, which is usually very fat and thick, is pushed aside and upward. The intestine is drawn out of the wound, but not more than necessary for access to the part to be operated upon. To prove the efficacy of this device it was not deemed necessary to excise several inches of gut. Therefore, now introduced, as there is no material difference in their weight. The purse-string is then drawn tightly and tied, causing the gut to pucker and snugly hug the cylinder. After both ends of the gut are thus prepared, the parts are flushed with warm normal salt-solution or boiled water, and the male cylinder is introduced into the female and firmly compressed. As an extra precaution or safeguard against premature absorption of the button in my early cases, I introduced five or six Lembert sutures. In the last of this series I omitted this procedure, and was equally

successful. Whenever there was a rent in the mesentery this was united by a continuous suture of fine black silk.

The animals usually recovered promptly from the anesthetic, and insisted on staggering about their cage. This can be avoided by tying the legs together. In none of the cases did the animal display any signs of inconvenience or suffering, if wagging of the tail is a symptom of well-being. It was found that when no food or water was given in the first 24 hours there was no vomiting. The dressing of iodoform gauze was usually removed, along with the sutures, on about the seventh or eighth day, with the wound firmly healed. The technic of introducing this button is precisely the same as that for the Murphy button.

Gastro-enterostomy can be done in from eight to twelve minutes, end-to-end approximation easily in ten minutes, including closure of the abdominal incision. The telescoped cylinders were passed by the anus in from six to nine days after intestinal operation, and in from eight to fifteen days after gastro-enterostomy. Cholecystenterostomy, or pylorectomy, was not performed, this work being reserved for a future series of experiments.

In these experiments fourteen large dogs (male and female) were used, all of the mongrel type. Gastro-enterostomy was performed six times, and end-to-end approximation eight times. Four animals died, one from heat-exhaustion, two in consequence of faulty technic, and one from intestinal obstruction on the seventh day. In the latter case I used, at the suggestion of a veterinary surgeon, an undecalcified button. The button was found near the sigmoid flexure, in the centre of a large circumscribed abscess, and but slightly digested. I made this experiment because it is a well-known fact that the canine family is capable of digesting bone, which forms a considerable part of their diet. This experiment proved the uncertainty of the digestion of bone introduced from without into the intestinal canal. Failure in two cases was due to premature absorption of the fully

Fig. E. Interior view of intestinal end-to-end approximation two months after operation.

decalcified buttons in gastro-enterostomy. As has been stated, the buttons should have been prepared according to Senn's method. The fourth dog rallied well from the operation, but, the weather being excessively warm, the animal perished 24 hours later from the effects of the heat. Examination proved that there were no ill effects from the operation. All of the experiments were conducted during very warm weather, which was a drawback.

It will be noticed that the cicatricial ring in all these specimens is very slight,

II. That the accomplishment of union is the same.

III. That the time required is the same.

IV. That the results are the same.

V. That there is considerable diminution in the size and weight of the foreign body to be discharged.

VI. That there is lessened danger from obstruction, gangrene and retention.

VII. That there is less liability for the button to travel in a reverse direction.

VIII. That this research proves this

Fig. F. Interior view of intestinal end-to-end approximation four and one-half months after operation.

and the caliber is as well, if not better, maintained than after the use of the metallic button. This proves that pressure-necrosis can be secured by decalcified bone buttons.

These specimens were taken at random from this group of cases. The results were uniform throughout.

As compared with the use of the metallic button, it may be said of the decalcified bone button:

I. That the technic is the same.

button capable of effecting a very even union of the intestinal walls without pseudo-membranous adhesions.

IX. That the line of union shows no tendency to subsequent contraction.

X. That there need be no dread, as in the use of the heavy metallic button, whose sojourn in the intestinal canal is indefinite, and tends to create anxiety to both patient and surgeon.

The buttons were made for me by Messrs. C. Lentz & Sons, of this city.

REMOVAL OF A SARCOMATOUS THYROID GLAND WITHOUT AN ANESTHETIC—IMPENDING DEATH FROM SUFFOCATION.

GWILYM G. DAVIS, M.D., M. R. C. S. Eng., PHILADELPHIA,*

A man, aged thirty years, came complaining of a tumor of the neck, and the following history was obtained: He said that he was well until three months previously, when he noticed a small swelling on the front of his neck. This remained small until six weeks prior to his admission to the hospital, when it began to increase in size; during the last three weeks this increase was very rapid, indeed. The growth had not occasioned much pain, but recently difficulty in breathing and in swallowing had developed. The voice became hoarse and there was some cough. Pain was felt in the neck and around the shoulders. Examination revealed a tumor the size of an orange, round and tense, but with a feeling of apparent fluctuation. It was somewhat tender to the touch. The median line of the growth was slightly to the left of the median line of the neck, and the tumor reached from the supra-sternal notch to well up on the thyroid cartilage. It moved somewhat on swallowing, but was evidently attached to the surrounding tissues, thus preventing free motion.

A casual examination caused me to regard it as a tumor of the thyroid gland, and from its extremely rapid growth and obscure fluctuation, possibly largely cystic in nature. At all events I decided to incise and evacuate such cysts and portions of the growth as would tend to liberate the imprisoned trachea, and thus relieve the breathing. It was proposed to use ether as the anesthetic, provided it was well borne; if not, then chloroform. On beginning the administration of the ether the breathing became labored. The anesthetic was immediately removed and the patient allowed to sit up on the operating table, with the expectation of the breathing becoming better. Instead of doing so it became worse. The man's face became pale and his lips blue; the air could plainly be heard hissing in and out of the constricted air-passages.

It soon became evident that the breathing was not going to improve and that if relief was not given the patient would die in a few minutes. The man was then induced to lie on his side, with the head and shoulders raised, and an incision was made into the tumor. Only blood came, and the finger revealed a solid but soft growth. The dyspnea becoming more urgent an incision was then made at the upper edge of the tumor, and rapidly deepened until the hyoid bone was felt. It was intended to cut down and see whether an opening could be made into the trachea above the growth, and thus allow of a tube being passed downward beyond the obstructed part, and enable the patient to get some air.

It became evident that the growth had encroached so high up on the larynx that an exposure of the lower border could only be obtained by cutting through the whole thickness of the tumor, a proceeding that in itself might have proved fatal from hemorrhage; so, with the idea of relieving the pressure of the tumor on the trachea, the incision already made was prolonged downward to the supra-sternal notch and deepened with a few strokes of the scalpel until the tumor was exposed. Two hemostats served to hold the tissues apart, and, grasping the growth with forceps, it was pulled forcibly up, away from the trachea. This seemed to improve matters somewhat; so, handing the forceps to an assistant, the soft parts were rapidly dissected aside, the thyroid arteries and veins clamped and the whole growth loosened from its attachments, proceeding from below upward, and removed. A small piece of the right lobe was allowed to remain. It was connected by a flat fibrous band to the growth, which arose from the remaining portion of the gland.

So soon as the tumor was raised the

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trachea was seen compressed and pushed to the right side. The patient, who by this time was almost dead, began breathing again and soon was perfectly sensible. Comparatively little blood had been lost. A drainage-tube was inserted at the lower angle of the wound, and the remainder closed with interrupted sutures. Recovery from the operation was prompt, the drainage-tube being removed on the fourth day, leaving a granulating spot, half an inch in diameter, and the patient was soon up and around the ward. There was slight suppuration around a couple of the upper stitches, due to infection of the wound by the patient picking it and thrusting his fingers under the edge of the dressing. The neck, instead, however, of remaining soft, soon became hard and brawny, and the drainage-tube opening, instead of healing, became the seat of a recurrent growth. The tumor that had been removed was a grayish-white mass, possessing in some places a fairly distinct capsule; at others, however, it was adherent to the surrounding tissues, which were evidently affected by the malignant process, but not to such an extent as to enable it to be appreciated by the sense of touch. By the end of the third week after the operation the recurrent growth at the site of the drainage-tube opening was quite large. The breathing again became much embarrassed, and another attempt at relief became imperative. Chloroform was administered and a mass the size of an egg removed. This was only partially encapsulated, was very soft and broke into a pulpy mass, which had to be scooped and curetted away. The neighboring tissues were everywhere infiltrated.

Some relief followed this operation, but within a week the growth again appeared at the site of operation, and on the ninth day, early in the morning, the patient had an attack of dyspnea, went into convulsions and died in a few minutes. Post-mortem examination by the pathologist, Dr. Stengel, revealed a malignant growth extending from the sternum, below, to the tongue, above, and from the vertebral column, posteriorly, to the skin, anteriorly. The large blood-vessels of the neck were imbedded in the mass of the tumor; the trachea was pushed to the side and compressed; and the esophagus, also involved, lay flattened by the mass against the vertebral column. Search was made for a point of rupture into the veins, but none was found. The lungs were also affected. Microscopic examination showed the tumor to be a spindle-cell sarcoma, with some, but not many, round cells.

There are few things in surgery that are so terrible and demoralizing to a surgeon as to have a patient in apparent robust health die on the operating-table. Should death take place soon after, or even during, an operation on a case *in extremis*, like those suffering from intestinal obstruction, then one would not feel so badly, because the contrast between life and death is not so marked, and one's own responsibility not so evident. In the case just related the patient had been up and walking around the wards conversing and associating with the other patients, and his sudden death would have been directly attributable to the operative attempts. Twice before have somewhat similar events occurred to me. While resident surgeon in the Pennsylvania Hospital, serving under the late Professor Agnew, a young girl was admitted with a nasal polypus. I was entrusted with its removal. All attempts to effect this by grasping the formation with forceps and trying to draw it out failing, ether was given and another effort made. In this the pedicle broke and the tumor slid back into the pharynx. The patient stopped breathing at once, it being impossible for any air to enter, became blue and seemed at the point of death. Hastily turning her on her face, with the head hanging over the edge of the bed, a vigorous thump on the back dislodged the obstructing body and out came an enormously large, soft polyp.

The third case occurred last year. My resident was instructed to operate for circumcision on a boy about nine years of age, in an adjoining room. The operation was satisfactorily performed and finished, when, hearing a commotion, I entered and found the patient in the throes of asphyxia. The face was congested, the lips blue, the teeth clenched and the mouth covered with vomited matter. Realizing

the state of affairs, the jaws were pried slightly apart with the hands, and thrusting a forefinger between the teeth, I succeeded in dislodging a piece of meat that was impacted in the opening of the larynx. The patient was lying face down, with the head over the edge of the bed, and slightly drawn back. The obstruction was no sooner removed than attempts at respiration induced vomiting again, and again was it necessary to clear the fauces with the finger. This continued for several minutes, and not until the stomach had been emptied of its contents did the asphyxia disappear and the natural color of the face return. This patient was as near the dividing line between life and death as the other two patients, and I trust to be spared a repetition of the experience.

The first case illustrates forcibly the irritating effects of ether on the respiratory passages. It had been intended to discontinue the ether if not well borne and substitute chloroform, but the effects of the irritation caused by the ether did not disappear on its withdrawal, and it was necessary to operate without any anesthetic. This serves to demonstrate the fact that ether is not always the most suitable anesthetic. Cases arise in which one should either employ chloroform or no anesthetic at all. In this country the objection to the use of chloroform is so strong that many physicians never have used it, while others resort to it only in very rare cases. Personally, I believe that most of the objections that have been urged against it are well founded, and that it is a treacherous agent, with a powerfully depressant effect on the circulatory system. Whenever it is possible to do so I use chloroform only to induce anesthesia and then substitute ether. In the surgery of the respiratory passages ether is particularly objectionable. When there is inflammation or a tendency to edema, then the irritating effects of the ether will, either by directly aggravating the existing condition or by inducing an outflow of tenacious mucus, cause interference with the breathing. In the case cited the dyspnea was thought to be due more to narrowing of the lumen of the trachea by direct pressure of the tumor than to inflammatory swelling or edema, and that was why it was decided to try ether. The fact of the dyspnea progressively increasing even after the ether had been withdrawn shows how persistent its evil effects on the respiratory passages are. The use of an anesthetic also predisposes the patient to septic pneumonia. In other operations on the air-tracts, as in tracheotomy, I usually operate without an anesthetic, or else administer chloroform until consciousness is lost and then rapidly complete the operation without it. In cleft palate I have used both chloroform and ether and am not entirely satisfied with either. Perhaps a combination of the two, as suggested by Dr. Mears, is best.

In the case of the nasal polypus attempts had been made to use a snare, but without success, and even had it been used the same accident might have happened. It is an occurrence that may take place at any time in the removal of large growths through the fauces. Had the thumping failed to dislodge the obstructing tumor my next move would have been to have introduced the finger to remove it.

The trouble in the last case was due to the child having eaten a hearty meal not long previously to the operation. He had been brought to the hospital for the operation and it was impossible to have him properly prepared. The case shows the danger of administering anesthetics on a full stomach. The main difficulty in this case was to gain access to the pharynx. It is certainly common for anesthetics to be administered when no appliance is at hand with which to open the jaws. In European clinics, where chloroform is the anesthetic usually employed, it is customary to have ready for use a mouth-gag or forceps with which to pry or force the teeth apart in case of necessity. In this country many anesthetizers will have forceps at hand to pull the tongue forward, but nothing with which to pry the jaws open. In some cases the physician must gain access to the throat at all hazards and that quickly, or the patient will die. In the one here detailed, fortunately, we were able to force the teeth slightly apart, and, at the cost of a certain amount of laceration, push the forefinger into the mouth. In the case of an adult and even

of some children this might have been impossible and resort to tracheotomy would have been necessary.

We really have no very satisfactory manner of opening the jaws when firmly clenched. The various forms of forceps and gags devised by Roser and others, while efficacious, are likely to break the teeth. Probably as good a means as any is to have a wedge of wood, about three inches long and an inch thick, and force this between the teeth. This is simple and affords sufficient space to grasp and draw forward the tongue or to introduce the finger and dislodge any foreign bodies that may be present.

THE MEDICAL INSPECTION OF SCHOOLS.*

E. C. JONES, M.D., PHILADELPHIA.†

It is a well-known fact that the schools tend to increase, by the necessarily close contact of the children, the spread of contagious diseases. This statement is abundantly sustained by the daily experience of physicians, who are frequently able to trace the contagious disease in a child to his attendance at school. Some very striking figures, also confirmatory of this statement, are published by the Board of Health of Boston.[1] This table contains also all the cases of diphtheria reported in Boston for 18 years, arranged by months: January, 2185; February, 2391; March, 2252; April, 2074; May, 2185; June, 2185; July, 1573; August, 1509; September, 1840; October, 2915; November, 3415; December, 3593. This table shows that the months in which the lowest number of cases are reported are always during the vacation term, and the months when the highest number of cases occur are always in cold and shut-in months.

The following figures are in the same line: The results of the examination made in the Boston schools from November 1, 1894, to October 31, 1895,[2] are as follows: Fourteen thousand, six hundred and sixty-six children were examined, of whom 9,188 were found sick. The number found to be sick enough to send home was 1,745. Of these 427 were suffering from contagious or infectious diseases, as follows: Diphtheria, 70; scarlet fever, 26; measles, 110; whooping cough, 28; mumps, 43; pedicularis, 66; scabies, 42; congenital syphilis, eight; chicken-pox, 34.

These children were all in their seats, with the risk of spreading contagious diseases to the other children. It is impossible to compute the number of children saved both from contracting disease and from death by the removal of these 427 centers of contagion from the school.

Still further proof of the statement that the schools disseminate contagious diseases is found in the striking result of the first day's inspection of the schools in New York. On March 29, 1897, there were 4,255 children examined with the result of finding 14 cases of diphtheria, three of measles, one of scarlet-fever, three of mumps, eight of chicken-pox, eight of skin disease, 35 of contagious eye-disease and 55 parasitic diseases. When we consider that each child afflicted with a contagious disease (and the whole number in the New York schools amounted to 127) come into contact with dozens of other children, it is easy to see how rapidly and terribly contagion may be diffused through the schools.

The danger of contagious diseases being transmitted through the schools has been recognized for a long time, and during the last ten years has been actively commented on, and various remedies proposed; for instance, in 1882 the Boston Board of Health sent a communication to the School Board recommending that all school houses and school furniture be disinfected once in two weeks. Again, in 1894, it was recommended by the same board that the desks, chairs, window-sills and everything likely to be handled by

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† Read before the Woman's Health Protective Association.

[1] *Annals of Gynecology and Pediatry*, March, 1897.
[2] *Boston Medical and Surgical Journal*, April, 1896, article by S. H. Dargin.

the children, should be periodically disinfected by washing down with a solution of corrosive sublimate. In 1890 the Boston Board of Health recommended the daily medical inspection of schools, but it was not until the city had been visited by a severe epidemic of diphtheria that the authorities awoke to the immediate necessity of such an innovation. In Nov., 1894, such a plan was put into operation.

The best evidence of the success of this experiment is the fact that New York has lately followed suit, and on March 29, of the present year, a system of daily inspection of the schools was first instituted in that city.

Boston was the first city in the United States to make use of this method of prevention of disease, and it is a significant fact that Boston was also in the lead in the employment of vaccination in America, and that Philadelphia was ten years in following the example set by Boston in this method of preventing one of the most loathsome diseases with which humanity has to contend.

With the example and experience of Boston and New York before us, it seems incumbent upon Philadelphia to take up this matter of daily school inspection, and by this means reduce, if possible, the terrible amount of suffering and mortality from contagious diseases among school children.

Just the method best suited for our city would have to be developed, but probably the inspection could be employed along the same lines as it is employed in Boston and New York. In New York the medical inspectors are appointed under rigid civil service rules, and probably under such a just method the service of those best fitted for the work could be obtained. The cost of such an inspection, as shown by Boston and New York, is not excessive, and, in view of the results expected to be obtained, such cost is an inconsiderable objection.

CURRENT LITERATURE CONDENSED.

Rupture of the Quadriceps Extensor Tendon.[1]

A rupture of the quadriceps extensor tendon is not a rare accident, neither should its diagnosis be difficult, and yet from histories of such cases the impression is received that in many of them the injury was overlooked, because the examining physician was not alive to the possibilities of such an accident. In these cases it is of the utmost importance that appropriate treatment should be at once begun. There are certainly many cases where surgical treatment is not needed, but, on the other hand, in the majority of cases, when complete rupture has occurred, either above or below the patella, the results from non-operative treatment are far from satisfactory. This is especially so when the rupture is above the patella. In forty such cases, collected by Maydl, there was complete recovery in 60 per cent. only, and in the twenty-three cases collected by J. B. Walker in 70 per cent. Contrast with this the final result after suture in the twenty-one cases collected by Walker with complete recovery in 90 per cent. Such operations, however, are not devoid of risk, and while so far no disastrous results have followed it must not be forgotten that the majority of these patients have been under the care of surgeons of skill and experience. It is only by such men that the operation should be attempted, and if the proper conditions for an aseptic operation do not exist, it is probably wiser to adopt, for a time at least, a non-operative plan of treatment. Should this fail, the suture can be done at some later date, when the surroundings are more favorable for a successful issue.

The most favorable time for operation by suture is probably at the expiration of five or six days after the injury, when the acute stage of the joint hyperemia has subsided. While a delay of several weeks does not seem to be advisable, yet it does not contraindicate the operation. In the three operations recorded by Dr. McCosh, a delay of eight weeks in the first case did not interfere with a perfect recovery, while in the second case a similar delay seemed to influence in a slight degree the final result.

[1] ANDREW J. MCCOSH, M.D., of New York, in the *Annals of Surgery.*

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PHILADELPHIA, SATURDAY, MAY 22, 1897.

EDITORIAL.

HINTS FOR READERS AT MEDICAL MEETINGS.

There are frequently unpleasant experiences at society meetings which suggest the wisdom of more careful attention to the length and nature of medical papers, and to the number and arrangement of papers on the program. Too often the impression is irresistible that the readers have consulted personal vanity, rather than that they have felt genuinely called upon to publish information to their colleagues, and that the committee having the program in charge has consulted the preferences of active participants, rather than the convenience and edification of the listeners. Sometimes, indeed, the officers, committeemen, essayists and leaders of discussions have so far outnumbered the listeners, as to suggest the small boys' company of soldiers, with no one of lower rank than "high private."

The duties of a committee of arrangement should be similar to those of a magazine editor. Who, that is broad-minded enough to deserve consideration, would be offended if his offer of a paper were met with the polite information that the program was already fully provided, or that his subject was inappropriate, or that his paper was too long? Undoubtedly, some men would take umbrage if their names were omitted from the customary "provisionary program," but the sooner men of this stamp are eliminated from medical societies, the better. A particular meeting in point was virtually spoiled because the committee of arrangements were scoliotic enough to put on the program every title offered them, without regard to the obvious fact that the time allotted to the meeting was entirely too short for a care-

ful consideration of half the material at its disposal.

A committee on program was appointed, which soon announced that it would be necessary to limit the reading of papers to ten minutes each, the discussion to three minutes each. The absence of a reader was hailed with delight; the men who consented to have their papers read by title were regarded as benefactors; some who abstracted their papers were utterly misunderstood, and correspondingly criticised; discussions which promised much of interest were cut short at the rap of the gavel, and one eminent guest, who had prepared a paper of reasonable length on an important subject, openly rebuked the society, and declined to present his paper, contenting himself with a few remarks on the general topic. The meeting, representing an average cost of perhaps ten dollars a member, passed in the hysterical effort to get through with things as quickly as possible, and the members left with an intellectual surfeit, only comparable to the feeling of a man who has bolted a good dinner in five minutes, without having had time to taste the viands which have produced an uncomfortable gastric distension.

Some readers of papers seem to share the pride of the old minister, who preached two hours at a stretch. He was asked if the exertion had not tired him. "No," was the reply, "but it would have done you good to see how tired the people were." The length of a paper bears quite a definite relation to its nature, and the circumstances of its delivery. Except for some societies, in which the president is expected to furnish the main scientific paper of the session, it is a good rule that the presiding officer should make only the briefest remarks, and that nothing of a salutatory, eulogistic or historic character should occupy more than ten minutes.

An ordinary medical paper should require about fifteen or twenty minutes for reading. In spite of the advantage of condensed expression, it must be remembered that a subject really deserving the serious attention of a society can rarely be presented in sufficiently complete form in less than the time stated. We recall an instance in which a distinguished man, and a guest of a society, occasioned much embarrassment for himself and others, by occupying over an hour in the presentation of a technical paper, in which the members could scarcely even feign an interest, while the remainder of the program had to be either glossed over, or in part omitted. Strangers often ask for information regarding local customs, even in the matter of dress, why should they not feel as free to ask similar definite information regarding their subject, and the time at their disposal?

A man invited from a distance to read the sole paper of an evening, may well allow himself an hour, but this would be an extreme limit for one addressing his every-day associates. Otherwise, either the invitation should distinctly state the time allotted, or the reader should be courteous enough to consult the needs of his companions on the program. Nothing can be more boorish than the disregard for time affected by some men who happen to have, or have been honored with, an early place on the program. Especially does this hold true when the speaker is the presiding officer, or another whose function is obviously an honorary one, and whose duty is plainly to dispose of the customary platitudes with the greatest expedition compatible with dignity.

Many papers are too long or too short, relatively to the occasion on which they are read. Articles dealing with abstruse science, or the details of a specialty, are in the worst possible taste when delivered to a miscellaneous assemblage of physi-

cians. The pathologist or the practical specialist is often called to address such bodies. In such cases, he must be guided by the Golden Rule, almost as a matter of etiquet. He should certainly occupy only a few minutes of the time of the meeting, and, just as certainly, he should discuss some topic in its practical bearing on clinic medicine, or which shall at least have a deeply interesting and general scientific application.

On the other hand, a gathering of men, technically trained in some one branch of science or medical art, might well feel that the paper which was adapted to the general practitioner would contain only such statements as they would consider rudimentary, and which should be taken for granted, as the foundation of a more elaborate article.

We may conclude with a few suggestions, which ought not to need stating, but which are very commonly ignored. The reader of a paper should be familiar with his article, so that he will not be obliged to delay his audience while he deciphers bad hand-writing, or tries the various inflections which ambiguous expression and lack of punctuation allow. He should also know the proper pronunciation of words, especially those not readily suggested by the context. We recall an instance in which a somewhat technical metaphor was repeatedly used, alluding to the development of butterflies from the larva. The reader spoke, over and over again, of the ī′-mago with a long i, and with the accent on the first syllable. It is scarcely necessary to add that the gist of his meaning was not understood till his paper was nearly finished.

Many readers seem to have no idea of the length of their papers. A fair delivery before a small audience is about 120 to 140 words a minute. By counting one average page of an essay, the time of delivery can be estimated very closely. If the hall is large enough to require some strain of voice, few non-professional orators can deliver distinctly more than 100 to 120 words a minute. Finally the sheets of manuscript should be arranged in order and should not be folded or rolled so as to be almost illegible.

CORRESPONDENCE.

INTERESTING OBSERVATIONS ON A NEW PUBLICATION.

EDITOR OF THE REPORTER:—A volume of more than usual interest to the profession is that upon Diseases of Women and Uterine Therapeutics, by H. Macnaughton Jones.* The book is one that has excited quite a good deal of interest, and possibly a few criticisms from a personal standpoint will be of interest.

Chapters VI, VII and VIII, treat of "Disorders of Menstruation," and the elucidation is an excellent presentation of the subject; yet we are all impressed with the fact, and compelled to admit that many of these "misplacements," as well as "Disorders of Menstruation," are largely due to the unhealthy habits of living, and the objectionable modes of dress of many of our young women; and the resultant lack of vigor, and vigorous development, may also explain many cases of "anteflexion and retroflexion." The author's remarks on "prolapse of the uterus and retroversion" are full of practical instruction. It is a subject that will admit of almost endless investigation; a whole history of pathologic conditions may, many times, be learned from a retroversion.

* A review appears elsewhere.—ED.

Chapter XIV, on "Inflammation of the Uterine Tissues," and chapter XV, on "Laceration of the Cervix," are worthy of the most careful thought of every physician and surgeon. Cervical lacera-tion will often be found to be the out-come of uterine inflammation. In my microscopic investigations of the changes produced in the cervix by inflammation, I have repeatedly demonstrated that, as a consequence of inflammation of the cervix, the muscle fibres are changed to fibrous connective tissue, and this, not being able to expand as does muscle fibre, breaks or tears, hence the laceration. Dr. T. A. Emmet did a good work in show-ing that lacerations should be repaired;* and when a laceration of the cervix, how-ever deep or transverse, is properly and antiseptically repaired, the patient is well in a week or less time; but when a patient is sick six or seven weeks in consequence of this operation (I know of one such in-stance in Brooklyn, N. Y.), the operation was not properly done, or there were pre-existing conditions that contra-indicated the operation. If pelvic inflammation follows this operation, it must come from one of these causes, and if it is developed, the patient is in a worse condition than before the operation.

The fact that cancer or malignant dis-ease so often follows, or is developed after a laceration, is another reason why the in-jury should be repaired. Irritation of the everted internal membrane may be a fac-tor in producing cancer. In my own prac-tise, I have never seen a case of malignant disease of the uterus, but there was a pre-vious laceration of the cervix. Further, laceration of the cervix causes more or less inflammation, and for cancer to be devel-oped, the tissues must first be reduced to medullary corpuscles, which is their con-dition in inflammation. The author sub-stantiates this by saying on page 334 of his volume, "I believe the predis-posing cause of serious uterine diseases lay in an old eversion and erosion, the consequence of an unremedied rent in the cervix."

On page 333 the author says, "That the cervix uteri is more or less torn in a large proportion of cases all admit," yet I have found many women who have had large families of children, and some dif-ficult labors, yet have not a laceration of the cervix. On the same page the author quotes Emil Noeggerath that "women are more likely to conceive when there is a laceration than when there is not." This is a sad commentary on the uterus in its normal condition. I think it must be ad-mitted, that lacerations of the cervix are a frequent cause of sterility. In many women who have consulted me for steril-ity I have found this the whole difficulty; and in my article on "Sterility in Wo-men" (*Medical Record*, Sept. 19, 1891), I cite many instances of years of acquired sterility, in consequence of this injury, where, when the injury was repaired, the sterility was at once removed, and in each case the woman had one, three, five or more children.

These old lacerations are not only a cause of sterility, and a cause of malignant disease, but in their early commencement they are a prolific source of sepsis being introduced into the system, causing pelvic peritonitis or perimetric inflammation.

On page 466 we find the following observation: "Total extirpation of the uterus, as practised first by Bardenheuer and Martin on the Continent; by William Smyly and Jessett in Great Britain; by Baldy, Polk and Boldt in America." Is there not an omission here? So far as I know, I was the first person who did total hysterectomy for fibroid in America. No-vember 23, 1887, I presented before the New York Pathologic Society a uterus containing an intra-mural fibroid of some seven or nine pounds, removed by the ex-tra-peritoneal treatment of the pedicle, stating that the patient had the usual pe-riod of convalescence of thirty-seven or forty-two days. I then said that I believed a better and more natural procedure would have been to have removed the entire uterus, because: first, it would have short-ened the operation; second, there would have been less shock; third, less danger; and fourth, more rapid recovery.

February 16, 1888, I removed, by total hysterectomy, an intramural fibroid weigh-ing thirteen-and-a-half pounds, and the

* Leith Napier says (*British Gyn. Journal*) Em-met's operation, as now done, is so modified, that we owe little but the principle to his teaching.

patient was able to be up in five days, and practically well in twelve or thirteen days. The account of this operation was published in the *New York Medical Journal*, August 25 and September 1, 1888. I had then never before heard of total hysterectomy for fibroid being performed either in this country or Europe.

At the meeting of the Academy of Medicine, section for Gynecology and Obstetrics, March 28, 1895, Dr. E. W. Cushing, of Boston, presented a paper on "Evolution in America of Abdominal Hysterectomy and Total Extirpation of the Uterus," and said: "Meanwhile, another great advance had taken place, and that was the introduction of a safe and feasible method of removing the entire uterus through the abdominal incision. This was accomplished in 1888, *dux femina facti.*" Dr. Cushing then quoted from my article, above mentioned.

Soon after this meeting at the Academy of Medicine, Dr. H. J. Garrigues kindly called my attention to a paper published by Dr. Bardenheuer in 1881, in which year Dr. Bardenheuer performed total hysterectomy for a patient who had two subperitoneal uterine fibroids.

To this important subject of the treatment of the uterus fibroid, Dr. Macnaughton Jones devotes sixty-four pages, a most clear and beautiful presentation of the whole subject. He then speaks of "Enucleation by Celiotomy of Interstitial Myomata;" also of "Enucleation and Morcellement," as practiced by Emmet, though, as the author says, "Pean's name is mainly associated with the latter step, and that even Pean himself occasionally had to abandon this and resort to total hysterectomy. In 1886 I saw Pean remove a fibroid by morcellement. When he had finished, the patient did not look as if she could survive an hour. Abdominal hysterectomy would seem to have been a much safer and more expeditious method."

Dr. Macnaughton Jones also discusses "Salpingo-Oophorectomy of Fibroid Tumors," and in this connection gives the best reasons for objecting to the term "castration." Then follows the operative procedures for the removal of fibroids, giving the relative risks and mortality for the various methods. The author next gives fifty-six pages to the discussion of "malignant growths." On page 515 he refers to my microscopic investigations on the subject of cancer, and copies four plates as they appeared in my article on "Carcinoma on the Floor of the Pelvis" (*Medical Record*). In that article I called attention to the fact that, so far as I know, had never before been mentioned, *that inflammatory corpuscles change to cancer epithelia;* also, by high powers of the microscope, it was for the first time demonstrated that the lymphatic vessels carry their burden of epithelia.

On page 548 the author refers to my article on "Colpo-hysterectomy for Malignant Diseases," which appears in the *American Journal of Obstetrics* (Vol. xxvii, No. 5, 1893), saying, that "She (the author) evidently ranges herself rather on the side of localists in the etiology of cancer, and, as I believe, in the power of the knife to effect a cure in a fair proportion of cases. In this view I am quite with her." Next, Dr. Macnaughton Jones gives clearly the different methods of various eminent surgeons for performing vaginal hysterectomy for cancer.

In the chapter on the indications for the operation "Salpingo-Oophorectomy," a most momentous subject, on page 615 the author quotes me as saying: "I make the uncompromising sweep of excluding all cases from this operation, except when there is helpless disease of the organs themselves," and on page 612, he quotes Sir Spencer Wells as stating "Startling instances where the operation has been advised and declined, and the women have afterwards married and had children." My microscopic researches thus far show, that when there is profound disease of the ovaries, the *ova* are also ruined.

Among the affections of the ovaries, the author refers on page 616 to "Gyroma and Gyromatous Formations," and quotes what I said in *American Journal of Obstetrics*, February, 1888: "Nerve fibres packed in this dense tissue would explain a number of pathologic features of the nervous system depending upon diseased ovaries;" or, as I said in the *New York Medical Journal*, May 10 and 17, 1890, "Such dense formations would seem sufficient, by

pressing upon the delicate ovarian stroma, to excite the most serious inflammation." On page 664 Dr. Macnaughton Jones gives the nature, pathology and symptoms of "Endothelioma of the Ovary." This disease is no doubt more frequent than is generally supposed, and is the cause of much distress and suffering, and oftentimes eventuates fatally. On page 613, under subject "Salpingo-Oophorectomy," the author gives a most interesting instance of the removal of "an ovarian blood-cyst." The patient, in 1883, at the age of twenty, had an attack of pelvic peritonitis, a recurrence in January, 1884, six months later, another attack, and after she continued to suffer with abdominal pains. In 1886 she was married; in 1889 an enlargement of the left ovary was diagnosed; in 1892 the recurrent pains, of which she had suffered more or less for years, became more constant. In February, 1893, the author performed salpingo-oophorectomy, the left ovary was found completely bound down with adhesions, and was converted into a blood-cyst about the size of an orange. This was removed with its corresponding tube, and on May 31, 1896, the patient was delivered of a male child.

This is clearly a case of endothelioma of the left ovary. The growing endothelioma would explain the pain from which the patient suffered for years, and finally the formation of the "blood-cyst." If the blood-cyst had not been removed, it might have ruptured into the peritoneal cavity with fatal results. Also, removing it allowed the other ovary to perform its functions. Dr. Charles N. D. Jones once removed a similar diseased ovary in a sterile woman, and in three years she gave birth to as many children.

MARY A. DIXON JONES, M.D.

BROOKLYN, N. Y., May 16, 1897.

LIBRARY TABLE.

LECTURES ON APPENDICITIS, and Notes on Other Subjects, by Robert Morris, A.M., M.D., Fellow New York Academy of Medicine, A. M. A., etc. Second Edition revised and enlarged, with illustrations by Henry Macdonald, M.D. Cloth; pp. 173. New York and London, G. P. Putnam's Sons.

The style of this volume is peculiarly prepossessing, printed on heavy super-calendered paper, with typography not to be excelled. The subject matter has become familiar to the profession through the former edition, and that it has been considered timely and valuable is evinced by the demand for the work. Space is devoted to the preparation of surgeon and patient, a description of the appendix, a history of the disease, including etiology, symptomatology, etc., and a detailed description of the surgical treatment. Among the "other subjects" treated of in the volume are: The action of various solvents on gall-stones, the influence of remains of the embryonic vitelline duct in the production of moist navels and of eczematoid inflammation about the navel; malignant islands at the navel occurring simultaneously with malignant disease of the abdominal or pelvic organs; a last resort hernia operation; the experimental production of ileal intussusception with sodium carbonate; the reason why patients recover from tuberculosis of the peritoneum; the prevention of secondary peritoneal adhesions by means of an aristol film; another method for palpation of the kidney; experiments germane to the subject of abdominal supporters after laparotomy; an addition to McGuire's operation for a supra-pubic urethra; the drainage wick; ovarian transplantation; healing through the agency of a blood clot; hysterectomy for placenta previa, etc. Despite the feeling on the part of so many of the profession that there is no call for the multiplicity of books, this volume is one that should attain even greater popularity than it has, since no one will regret its purchase.

THE Macmillan Company is to publish CONSTIPATION OF ADULTS AND CHILDREN, with special reference to habitual constipation and its most successful treatment by the mechanical methods, by H. Illoway, M.D., formerly Professor of the Diseases of Children, Cincinnati College of Medicine and Surgery, etc.

SYRINGOMYELIA, an essay, to which was awarded the Alvarenga prize of the College of Physicians of Philadelphia, for the year 1895; by Guy Hinsdale, A.M., M.D., Fellow of the College of Physicians of Philadelphia and the American Academy of Medicine, assistant physician to the Orthopedic Hospital and Infirmary for Nervous Diseases, and attending physician to the Presbyterian Orphanage, etc. Cloth; pp. 74; illustrated. Price, $1. Philadelphia, P. Blakiston, Son & Co.

This essay, evincing an unusual amount of research and original labor, is in the form of a bound reprint, with exceedingly full illustrations, and is as complete a resume of known facts in this somewhat obscure pathologic condition as is available. The style of the arrangement of the treatise is excellent, and the studies of individual cases very thorough. If a criticism might be made, it would only be upon such minor points as difference in headings, as of symptomatology, etiology, etc. Author and publisher are both to be congratulated upon the production of a valuable contribution to current medical literature.

DISEASES OF INFANCY AND CHILDHOOD, for the use of students and of practitioners of medicine; by L. Emmett Holt, A.M., M.D., Professor of the Diseases of Children in the New York Polyclinic, etc., with 204 illustrations, including seven colored plates; cloth; pp. 1117. New York, D. Appleton & Co.

Frequent complaint has recently been made that in view of the rapid advance of knowledge in the field of children's diseases in the past few years, the literature on the subject, in the form of text-books, seemed inadequate. Hence the present volume will be welcomed by a large clientele for that reason alone, apart from the many points of merit apparent upon even the most casual inspection. The volume appears to be confined distinctively to those matters which are peculiar to early life, omitting the consideration of questions relative to operative surgery, and the pathology and symptomatology of disease in children after they have passed their seventh or eighth year, when the conditions differ but little from those of adult life. Subjects relating especially to general medicine are also purposely omitted, but especial space is devoted to the pathology and description of lesions, which are as a rule insufficiently treated of in current works on pathology, while their understanding is indispensable to the correct comprehension of the diseases in which they appear, exceptional facilities for post mortem work having been utilized in this connection. Considerable space is given to the study of nutrition and of the diseases resulting from its derangements, and a point of interest is that in treatment more stress seems to be laid upon diet and hygienic measures than upon drug-giving. Although the chief value of the work lies in the line of a text-book for students, it should have its place in the library of every practitioner.

DISEASES OF THE STOMACH, by Dr. C. A. Ewald, Extraordinary Professor of Medicine at the University of Berlin, director of the Augusta Hospital, etc., translated and edited, with numerous additions, from the third German edition by Morris Manges, A.M., M.D., assistant visiting physician to Mount Sinai Hospital, Lecturer on General Medicine at the New York Polyclinic, etc. (Second revised edition.) Cloth; pp. 602. New York, D. Appleton & Co.

In few departments of medicine has there been so much progress made in the past half decade as in the knowledge of disorders relating to the digestive tract, particularly those of the stomach. Hence a new edition of this valuable work, bringing it up to date, became a necessity. The translation seems exact, and is based upon the German edition of 1893. Where later views seem to differ from the author's conclusions, such have been appended. The drawings are noticeably an improvement upon those of the former edition, and there are also a greater number of them. The arrangement of the chapters has also been altered, and considerable new matter has been incorporated. Praise must be accorded to the indexing, a feature too often incomplete in medical works, but which in this volume seems beyond criticism. Praise of the work itself would be a work of supererogation, since the distinguished author is the recognized authority on stomach diseases, and his book has been so long accepted as covering the field to the fullest extent. It is a standard whose superior has not yet been issued. The numerous notes, etc., of the translator add greatly to the value of the volume, doing much to render it a medical classic.

ANSWERS to inquiries from housekeepers all over the country is a special feature of *Table Talk*, and is most ably handled by Miss Cornelia C. Bedford. It also gives daily menus for the month, with evening dinners or with noon-day dinners, besides some menus for special occasions. To any of our readers who will send name and address, the Table Talk Publishing Co., Philadelphia, offer to mail a sample copy of their magazine, free.

LIBERAL EDUCATION AND LIFE, (pamphlet). An oration delivered by Charles Richard Williams before the graduating class of Lake Forest University on Commencement Day, 1896.

It is interesting to recall that Mr. Williams, now editor of the Indianapolis *News*, and formerly secretary of the Associated Press, was, for several years, Professor of Classic languages, or at least of Greek, at the University before which this eloquent address was delivered. Both by derivation and in its essence, Mr. Williams insists that *liberal* means free and not book-education. One of his sentences applies so aptly to the matter of medical training, and particularly at a time when there is a dangerous tendency to regard the medical school as the main factor, that we quote it: "Such an education, I insist, is not so much attainment as development, not so much knowledge as power, not so much data as principles, not so much accumulation of facts as capacity to correlate and draw inferences and use. . . ."

THE INTERNATIONAL MEDICAL ANNUAL AND PRACTITIONER'S INDEX, a Work of Reference for Medical Practitioners, English and American. Cloth, 8vo., pp. 724; price, $2.75. New York and Chicago, E. B. Treat.

Few publications enjoy a larger circulation among the medical profession than this familiar volume, which, with the present edition, completes its fifteenth year. The medical field is briefly, yet thoroughly, reviewed, with well-written condensations of current literature by competent authority. The review of new remedies and of therapeutic progress is particularly valuable. Among the more notable departments we cannot refrain from noticing the review on ophthalmology by Dr. G. E. DeSchweinitz, Herbert Allingham's work on rectal diseases, and Dr. Thomas More Madden on Obstetrics. The article on Insanity by Dr. James Shaw is also a valuable one, profusely illustrated and well written. The work should be much appreciated by the busy practitioner as a reference volume for the approved and successful modes of treatment. It considerably exceeds in size former volumes, but remains at the same price.

PHYSICIANS' BLUE BOOK. This pamphlet contains the names of about three thousand delinquent debtors, for Buffalo and vicinity. The plan is to furnish revised lists at intervals of a few months, the pamphlets being rented for the use of subscribers.

INTERNATIONAL CLINICS, Vol. I., Seventh Series, April, 1897, J. B. Lippincott Co.

This quarterly magazine, in book form, is now familiar to the profession. The present issue is, perhaps, not so interesting to the average practitioner as many that have preceded it, much space being devoted to the specialties and to reports of cases, unique but either hopeless from the therapeutic standpoint, or otherwise failing to furnish an object lesson to the physician. From the very beginning of the publication of International Clinics, the editors have had to contend with the tendency of contributors to describe rare or aggravated cases. The volume opens with a lecture by Prof. J. William White, not clinical in itself, but summing up the experience of a series of clinics in "Rules Governing the Treatment of Appendicitis." Hemoptysis is discussed by Mays, and a very practical consideration of milk is given by Saundby, of Birmingham. We are glad to note that the latter makes no pretense at clinical form. Reed, of Atlantic City and Philadelphia, discusses excessive secretion of hydrochloric acid, which he considers a common complaint, occurring in nearly half of all cases examined. Other articles are of interest, but space can not be given to a detailed critique.

PRACTICAL MANUAL OF DISEASES OF WOMEN AND UTERINE THERAPEUTICS. For Students and Practitioners, by H. Macnaughton Jones, M.D. M. ch., Master of Obstetrics (Honoris Causa), Royal University of Ireland; Fellow of the Royal Colleges of Surgeons of Ireland and Edinburgh. Seventh Edition, revised and enlarged, with 565 illustrations. London, Bailliere, Tindall & Cox, 20 and 21 King William Street, Strand.

This is a scholarly and comprehensive presentation of the subject, accurate in its details, wise in its conclusions, and judicious in its directions; valuable for the practitioner, the surgeon, the professor, or the medical student. It constitutes an excellent text-book for the college course, and is a convenient book of reference. All its explanations are clear and explicit. Particularly fine are the chapters on "General Observations on Operative Surgery of the Uterus and Adnexæ," which are full of the most excellent practical directions; and those devoted to the surgical treatment of uterine fibromata, giving a full and clear presentation of operation, intra- and extra-peritoneal and total hysterectomy, the author giving a description of the necessary procedures and manage-

ment. Eighty-six pages are devoted to the subject of the ovaries, treating the subject with consideration and thought, and affording much valuable information. The book has 600 pages, is well illustrated and of excellent typographic finish.

THE second volume, strictly speaking, of Allbutt's SYSTEM OF MEDICINE (Dr. Playfair's work on Gynecology is a separate issue) is announced as ready for publication by The Macmillan Company. The contents of this volume include Infective Diseases of Chronic Course, *e. g.*, Tuberculosis and Leprosy; Diseases of Uncertain Bacteriology, Measles, Scarlet Fever, Mumps, Small-pox, Whooping-cough, etc., Typhus Fever, Yellow Fever, Dysentery, Infective Diseases Communicable from Animals to Man, Rabies, etc.; Diseases Due to Protozoa, Malarial Fever, etc. The book closes with some special papers on Intoxications, including Poisonings of various kinds, Alcoholism, etc.; Internal Parasites, and a few addenda to early articles. As usual, there are serviceable indexes, and all that is necessary to make a work of such great intrinsic value easy of reference.

SOCIETY REPORTS.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated meeting, April 28, 1897.

The President, DR. JAMES TYSON, in the chair.

DR. ORVILLE HORWITZ read a paper entitled

An Inquiry into the Cause for the High Mortality resulting from Supra-Pubic Cystotomy. Report of Seventy Cases, with but One Death.

(See page 609.)

DISCUSSION.

DR. M. PRICE expressed surprise at the high mortality recorded, not in Dr. Horwitz's own cases, but in the statistical records of the operation. Dr. Price has performed supra-pubic cystotomy three times for enlarged prostate and twice for stone, and he has been very much pleased with the operation in both instances. In the cases of stone, a diagnosis had not been made, although good men had seen them a number of times. No stone could be found, although all the symptoms of stone were present. In both cases the stone was encysted posterior to the urethra, and almost behind it. It was impossible when sounding to touch the stone at all. The bladder was opened above the pubis for diagnosis, as well as treatment that might be necessary afterwards. Both patients recovered nicely without any trouble.

In regard to the operation for enlarged prostate, Dr. Price did not think that any other procedure can begin to offer the same chances of success with so little risk. In his three cases the patients are wearing the Hunter McGuire button, for the reason that the mouth of the bladder has been almost entirely obliterated. One was a man 83 years old; another 81. The older man was an old friend, and had not attended his meeting for four years, because he was kept almost continuously emptying his bladder. When seen by Dr. Price his bladder was distended with three or four quarts of urine. The bladder was opened without any trouble, having been pushed above the navel, and there being no question of peritoneum it was perfectly safe to go directly in and empty.

Dr. Price did not believe that any drainage of the bladder, immediately after an operation, should be trusted to the drainage-tube itself. The tube is best made of rubber, because this does not irritate as much as glass. It should be emptied, not by gravity, but by syringe, and for a sufficient number of hours to avert extravasation. In the two cases of stone and enlarged prostate, Dr. Price opened the peritoneum, which gave him no especial anxiety. He used no rubber bag, no artificial means whatever; nor did he inject the bladder, but he simply went in, and brought the bladder up to the abdominal wound, protecting the peritoneum by gauze, whip-stitched the bladder around to its peritoneal border, and then put in not only a rubber tube, but gauze, packing the wound just at its union with the peritoneum.

In neither of these cases was there any trouble. It was quite a while before the wounds granulated and the patients could use the button. The drainage should be attended to by the nurse, and emptied with a syringe. In opening the peritoneum Dr. Price recommended, after the skin, fat and tissues down to the alba linea have been incised, the use of forceps, going down, picking up tissue and pulling it forward until the bladder is reached. In this way it should not take a man more than one and a half minutes to get into the bladder, while all need of a rubber bag in the bowel is obviated.

In regard to the supra-pubic operation for stone, Dr. Price felt so sure of the method being safer even than crushing, that if he had a stone in his own bladder he should insist upon its removal by the supra-pubic route. He would

rather have an inexperienced surgeon cut down on his bladder from above and remove stone, than permit a skilled hand to do so by crushing.

Dr. Price thinks castration for enlarged prostate uncalled for and unsurgical, and he does not believe that it will do all that is claimed. He referred to the case of an old man, 83 years of age, whose prostate was as large as two fists, and who lived four years after supra-pubic cystotomy, and then died of pneumonia. He could carry his water for three or four hours, the operation having given relief to the cystitis and the irritation.

Dr. John B. Roberts said that supra-pubic cystotomy is in itself almost free from danger. Of course there may be complications attending prostatectomy, such as diseased kidneys, perinephritis or pyonephrosis; but the operation is one of the easiest major procedures in surgery, and is certainly attended with a very low mortality. Ten or fifteen years ago, at the American Surgical Association, in a discussion on stone, the older men took the ground that the perineal was the best route. At that time Dr. Roberts predicted that the lapse of ten years would probably see the high operation and litholapaxy the usual operations for stone, and this conclusion has now been practically reached. The suprapubic section is by all odds the best operation.

It is not necessary to use the rectal bag. The Trendelenburg position, with about eight ounces of water in the bladder, seems to give perfectly satisfactory results. Dr. Roberts has never used air, but always water. He has cut the peritoneum once, but without ill result. The membrane was sutured before the bladder was opened.

One objection to the bag is that it rather increases bleeding. Pressure in the rectum interferes to a certain extent with the circulation in the veins. Dr. Roberts prefers the vertical incision, unless the bladder is a very small one. The transverse incision affords a beautiful view of the bladder, but the objection is that the muscles slide up in their sheaths, and it is difficult to bring the upper and lower portions together in closing the wound. The suture should be put in the upper portion of each rectus muscle, above the intended line of suture. The thread will enable the operator to pull down the upper end after the division. Men report the dangerous cases, and not the successful ones. The successful ones are not reported because they seem so easy. The operation is an exceedingly good operation, and Dr. Horwitz has done a service in bringing forward the fact that the mortality ought to be very low.

Dr. Ernest Laplace believed suprapubic cystotomy to be the operation to be performed whenever a source of irritation is to be removed from the bladder, or when the bladder is to be put at rest, and that comprises all the affections of the bladder demanding operation. The operation was not held in good repute at the time it was first practised, because the principles that make all surgery successful to-day were then little understood, and chief among them, drainage. To-day it is precisely understood what drainage ought to be, and its common-sense employment, with a simple knowledge of the anatomy of the bladder, makes this operation free from danger. In a discussion before this Society some time ago, as to the relative importance of the two operations, litholapaxy and suprapubic cystotomy, the consensus of opinion, because of the report of a number of cases by Dr. Kerr, from China, was that preference would be given to the former operation when it could be performed. Dr. Laplace then maintained the opposite, *i. e.*, that the ideal operation on the bladder was the suprapubic, because a plain incision into the bladder, made in a cleanly way, is less grave than working in the dark, as in litholapaxy, the surgeon not seeing what he is doing. In the hands of the best men the mucous membrane may be grasped and lacerated, and one cannot be sure that all stone has been removed, leaving no nucleus for more. Dr. Laplace has done personally suprapubic cystotomy thirty-five times, and has lost but one case, occurring in an old man, who died of uremia. The operation was performed a number of times for stone, and a number of times for tuberculosis of the bladder. For giving the bladder a rest there is no operation to be compared with it. For enlarged prostate, Hunter McGuire's button is of aid.

Dr. Orville Horwitz said that in several cases, in placing the drainage-tube in the wound and sewing it in place, he has put a suture loosely through the wound, and left it loose so as to tie it down after the drainage-tube was removed. He always removes the drainage-tube on the second day, unless he follows the Hunter McGuire operation. In this way one may be sure that the little opening will be closed at the end of from twelve to fourteen days, and no sinus will be left. Many operators state that they have difficulty in getting the suprapubic opening to close. This is due to leaving the drainage-tube in too long. Leaving a loose suture in, and removing it on the second day, has not proved successful. Stitching the edges of the bladder is very well in the Hunter McGuire operation, but in ordinary cases this is not a necessary procedure, and may be regarded as a waste of time. The drainage-tube applied in the way described has been all that is necessary.

It is not advisable to pick up the tissues over the bladder, after the recti muscles have been separated by hemostatic forceps, and then divide them, layer after layer, until the bladder is reached. The knife should not be employed after the sheath of the recti muscles had been divided, until it is desired to puncture the bladder.

In the case of the patient who had an enormously hypertrophied prostate, with stone in the bladder, it was impossible to introduce anything except a rat-toothed catheter, and that with a great deal of difficulty. The patient was told that it was probable that he had a stone in the bladder, in addition to his prostatic difficulty,

and that the suprapubic operation therefore was necessary. He was an enormously stout man, and not only a vertical incision was made, but also the incision of Treves, cutting muscles on both sides. When the bladder was opened a large part of the prostate was removed in the usual way. Six calculi were found, weighing together six and a half ounces. The hemorrhage was very profuse.

A portion of gauze was packed down into the wound. By the electric headlight it could be seen that the ureters were not blocked, and the gauze was allowed to remain four days. At the end of this time the patient was etherized again, and the packing was removed. The edges of the wound were curetted and approximated, and a drainage-tube inserted. This was replaced in three or four days by a soft rubber catheter. In a few days nice recovery followed. Therefore, if there is any tendency to the formation of a permanent fistula the patient should be put to bed, a soft rubber catheter should be inserted, and the wound touched with silver nitrate.

The bladder can be opened without the use of the rectal-bag; but with it distended with water the bladder is rendered more accessible. After the bladder is opened, and further interference is required, the floor of the viscus, instead of being deeply seated in the pelvis, is lifted well up, and manipulation is facilitated. The use of the bag does give rise to a little more hemorrhage in the walls of the bladder, but with ocular exploration the vesical veins can, as a rule, be avoided, and as soon as the water escapes from the bag the hemorrhage ceases. The rectal bag is, therefore, a decided advantage. If, however, the bladder is merely to be drained, as in case of retention of urine due to hypertrophied prostate, or in the operation for Hunter McGuire's button, the rectal bag is not needed.

Dr. Horwitz expressed the conviction that the crushing of stones in the bladder is a very dangerous procedure in the hands of the general surgeon, and even in the hands of the specialist as a general thing. As a rule the safest operation is suprapubic cystotomy in cases of vesical calculus. If the stone is small and the kidneys healthy, crushing would be indicated.

Dr. G. G. Davis read a paper entitled

Removal of a Sarcomatous Thyroid Gland, without an Anesthetic, with Two Additional Cases of Impending Death from Suffocation.

(See page 652.)

DISCUSSION.

Dr. M. Price said that many surgeons take risks in performing, in their offices, operations requiring the administration of an anesthetic, and he cited a number of instances in which death unexpectedly took place under these circumstances.

Dr. Horace K. Regar said that the late Dr. Goodell used to insist that it was impossible for the tongue to slip back in the throat, and any one who will attempt the experiment in his own person will be able to verify the truth of the statement.

Dr. Frank Woodbury said that Dr. J. Solis-Cohen has called attention to the liability of incarceration of the epiglottis in the throat by the constrictor pharyngei muscles. The belief that the tongue may fall back into the throat, and become an obstruction to breathing, is so general that there must be some basis of fact for it. Dr. Woodbury emphasized particularly what was said about the administration of anesthetics in offices of physicians or dentists, and called attention to the fact that many deaths from anesthetics occur in dental practice, dentists being in the habit of giving the anesthetic in their operating chairs. It is a mistake to assume that the danger from an anesthetic is reduced by the fact that it is administered for a minor operation. It was formerly taught that the great distinction between ether and chloroform is that the latter is a vaso-motor depressant. It is true that this feature of the physiologic action of chloroform is very prominent. The vaso-motor paralysis occurs early in the administration, so that after the inhalation of a few drops of chloroform serious vaso-motor paralysis may occur. Thus the practice of administering a few whiffs of chloroform to initiate anesthesia, to be followed up by ether, is not without danger. There are certain patients to whom ether is a depressant, and in the case first reported by Dr. Davis the Nelaton position would be a proper one in which to have treated the patient, instead of having him sit up on the operating table. In that case the ether had acted as a vaso-motor paralyzant, and the alarming condition of the patient was due to possibly this cause, although the mechanical obstruction to breathing that was present may also have played a very prominent part.

The risk of anesthesia from ether will depend largely on the quality of the ether employed. The use of inferior qualities has brought ether into disrepute in England. There are many surgical opeartions that can be done in a short time, in which an anesthetic is not necessary, and it is time that the profession took a stand on this point, and ceased to encourage patients to take anesthetics for trifling operations. No case of coma produced by an anesthetic is devoid of danger, and many of the minor operations can be done without disturbing the consciousness of the patient.

Dr. S. Solis-Cohen said that he has seen a great many operations on the air-passages in the practice of Dr. J. Solis-Cohen, who lays great stress on the necessity of operating under these conditions without a general anesthetic, unless it be absolutely imperative. In one case there was a large malignant tumor of the thyroid, pressing upon the trachea, and the operation proposed was a tracheotomy beneath the tumor. Upon opening the trachea a great

gush of blood occurred, and the patient was almost suffocated by the blood flowing into the windpipe by reason of the wall of the trachea itself having been infiltrated by the tumor. The hemorrhage came from some large vessel cut in the incision for the cannula. That patient, being conscious, could be raised and could assist, by efforts at coughing, in getting the blood out of his trachea, while a retractor was inserted and pressure made on the bleeding point. In this case there would probably have been instant death if the patient had not retained consciousness.

DR. G. G. DAVIS said, in regard to the performance of operations in one's office, that the surgical dispensary can be compared to one's private office, and it is positively necessary at times to do operations in these dispensaries because the cases are not of sufficient gravity to be admitted to the house, yet requiring treatment, such as cases of phimosis. The difficulty would hardly be avoided by the administration of ether after making sure that the stomach is empty.

As to the question of the tongue falling back, whether it be the tongue or not does not matter much. The epiglottis certainly does at times, and it can be raised from the opening into the larynx by certain positions of the head or drawing tongue forward. Dr. Davis is not so much alarmed at the obstruction to breathing that comes from the tongue, because his experience leads him to believe that it is ordinarily not dangerous, that is to say it does not persist to the point of seriously threatening life; but he fears the effects of the other causes, such as tumors, blood and the like. Dr. Davis considers the primary administration of chloroform as dangerous. He agrees with the statement that, as has been shown by many reported cases, death is liable to occur after the first few whiffs of chloroform; but there are many cases in children in which it is perfectly justifiable to run the risk of death from chloroform by administering the chloroform simply to quiet the child, at least to begin the operation. In one of the cases reported the patient, as soon as the ether was removed, sat up on the table, and, as it would have been rather awkward to attempt to remove a large sarcomatous thyroid gland with the patient in this position, a support of pillows a couple of feet in height was made on which he reclined on his side. Then as the incisions were made the blood flowed forward and away from the field of operation.

The whole question of operation on the air-passages hinges largely on the question of not using any anesthesia at all. That is Dr. Davis' preference, but practically one is compelled to use anesthesia in some cases. In cases of extensive cleft palate the denudation to the bone is sometimes such a long and troublesome operation that it is but just to the patient to employ an anesthetic, and it can be used without danger also in other extensive operations, for instance, those on the jaws.

DR. A. GRAHAM REED read a paper on

The Hot-Air Treatment for Rheumatism and Gout.

(See page 614.)

DISCUSSION.

DR. G. G. DAVIS said that when the English apparatus was brought to this country some excessive price was demanded for its loan or rental. Satisfactory substitutes, however, have been made which can be bought at reasonable prices. There is no doubt at all as regards the efficiency of the process. Its effects are marked, and it promises to be a rival to massage in the treatment of stiff joints. Dr. Davis cited the case of a man with stiffness following fracture, whom he instructed to make a copper cylinder about one foot in diameter, and sufficiently long to encase the hand and forearm to the elbow. The air-supply was regulated by a stop-cock, and one end of the cylinder was closed with copper, while the other end was provided with a wooden rim, about which was tacked an ordinary piece of thick woolen material. The cylinder was rested on a wire frame, and beneath it was placed a plumber's lamp. A Bunsen burner would do, but the plumber's lamp gives greater heat. Inside of this chamber, on a false bottom, was a piece of asbestos cloth, and the hand and forearm were covered with cotton, in the folds of which was placed a thermometer, and the woolen material tied around the elbow. The man was thus enabled to obtain a temperature of 350°, which he could maintain for from half to three-quarters of an hour. The improvement following the treatment was very marked. One of the objections to the method of treatment is the time that it consumes. Beside, somebody is required to attend to the apparatus, either the doctor himself or a trained assistant. He must be there during the entire period of administration to regulate the heat, and the time consumed is almost prohibitory so far as public patients are concerned. No doubt means will be devised by which the apparatus can be used more extensively than it is now, with consideration of both the cost and the amount of time involved in employing it.

DR. J. P. ARNOLD said that he has been treating two patients at the Presbyterian Hospital, with a very simple apparatus, since early last fall. One had a gouty arthritis of the knee, which had existed three years. There was fibrous ankylosis of the joint. The apparatus consisted of a copper cylinder 18 inches long and 16 inches in diameter, with perforations along each side to allow a current of air to pass through. The ends of the cylinder were fitted with wooden discs, with central openings of various sizes to fit different-sized limbs. Around these central openings pieces of mackintosh cloth, provided with drawing-strings, were tacked. A small hole was made in each disc, so that a thermometer could be placed in the apparatus. With two alcohol lamps a temperature of from 260° to 300° F. could easily be

maintained. In all the patients under observation there was very marked improvement, though it was slow. The cylinder is now being used on three or four patients in the wards of the hospital, and all are being benefited. The actual cost of the apparatus described would probably not be more than $1.50. It was made by the hospital tinsmith.

DR. S. SOLIS-COHEN said that the range of the therapeutic efficiency of the apparatus is a matter of doubt in his mind. The so-called Turkish and Russian baths do not fulfil the entire purpose; and there appears to be a considerable field of usefulness for the apparatus exhibited, as the reports of cases go to show. It is only by experience, however, that it will be learned which cases can be benefited, and which not. The simpler methods, of course, are preferable, because they can be carried out anywhere. Iti s necessary that the physician himself should superintend the administration of the hot-air baths for at least half-a-dozen times. Later they may be entrusted to a very well trained assistant. Patients may be severely burned by attempting to apply the treatment themselves.

DR. A. GRAHAM REED said, as regards the use of the cheaper instruments, he did not know but that they will afford good results, gotten up as they are, but from his observation he thought they will often prove failures. One fault of the Tallerman-Sheffield cylinder is that it is not properly lined so as to prevent the limbs from coming in contact with the metal. Dr. Reed would not care to take the English instrument and expect to be successful with it, for it needs so much attention on the part of the patient using it, as well as by the physician or skilled attendant, and yet it does do in the hands of the English what they say it will. If burns have happened, it must have been through inattention.

Dr. Reed has given over one hundred and twenty treatments without one blister, and that is saying a good deal for the American cylinder. It is readily controlled, and, if properly managed, can be used with perfect safety and satisfactory results.

Dr. Reed has had no cases but that were benefited, and he does not believe that there is any treatment so successful as hot air in curing cases of rheumatoid arthritis or gout. Massage is good, but it certainly does not reach obstinate chronic cases.

DR. G. BETTON MASSEY called attention to a somewhat similar subject introduced by Dr. Kellogg, of Battle Creek, that is the incandescent electric light bath. This consists of a large number of incandescent lamps, enclosed in a cabinet, which can be applied to individual portions of the body. Very good reports have been made by Dr. Kellogg and others as to the effects, which were attributed, not to the light, but to the heat. It was found that the temperature of the body could be raised more quickly and more conveniently by this method than by heating the air, as by steam. Perspiration was produced more quickly with the electric light than in any other way. Dr. Massey thought that the same results produced by the cylinder described might be produced by electric heat, and probably in a more convenient way, for it would allow of application of the heat to any portion of the body. As it is thus possible to apply the heat to the trunk and abdominal centers it would fulfil the indications in lithemic cases better than Dr. Reed's apparatus. Dr. Kellogg refers the effect of this light-bath to radiant heat only; but since the discovery of the effects of the X rays it is possible that the tanning of the skin that results from this application may indicate an action of the light itself.

COLLEGE OF PHYSICIANS OF PHILADELPHIA.

SECTION ON OPHTHALMOLOGY.

Meeting April 20, 1897. DR. WILLIAM F. NORRIS, President, in the chair.

DR. E. K. PERRINE reported, by invitation, a

A Case of Intraocular Tumor.

————————, a married woman, aged 61, presented herself at the German Hospital April 10, 1897, complaining of excessive pain and neuralgia in the left eye that had continued for five weeks, and caused frequent nausea and vomiting. The eye had been previously free from pain, although sight had been failing for twelve years, and for the past year had been entirely lost. The right eye is normal in every respect. Left eye: ptosis and edema of the upper lid, hyperemia of the conjunctiva, engorgement of the anterior ciliary vessels, steaminess and punctuate opacity of the cornea in its upper half, and slight loss of sensation. The inner half of the anterior chamber is filled with a mass that has pushed the iris forward in contact with the cornea, and extends from behind it into the pupillary space. The growth is of a dark-brown color, smooth and rounded. The bulging iris is atrophied at the ciliary border, where the growth appears to be attached, but is not ruptured. The margin of the iris on the temporal side reacts to light, and when dilated with atropin shows the lower border of the tumor, between which and the edge of the pupil the opaque shrunken lens, dislocated backward, can be seen. T. + 2.

The patient has twelve living children, and has always had good health. There is no family history of eye troubles or tumors. The growth is probably a primary melanosarcoma, originating from either the anterior portion of the ciliary body, or the posterior surface of the iris. The case illustrates the extremely slow growth of some forms of melanosarcoma, as compared with other malignant neoplasms, and the very late appearance of secondary glaucoma.

Postcript.—After enucleation macroscopic examination showed a dark-brown mass the

size of a pea, the diameters varying from 3 to 5 mm., attached to the ciliary body and iris, and a shrunken and opaque lens dislocated backward. No other growths could be distinguished.

DISCUSSION.

DR. H. F. HANSELL believed that increased tension in the case of tumors within the eyeball was not dependent upon the increased amount of material, or the alterations in the character of the contents of the ball, but to nutritive changes that induced secondary glaucoma. For this reason plus tension is a late sign of the disease, and its absence may not be a contraindication of the presence of an intraocular neoplasm.

DR. S. D. RISLEY has found that tension alternates,—sometimes it is high and again it is low; the latter especially after the tumor has perforated the coats of the ball.

DR. W. M. ZIMMERMAN reported that, in the case he had exhibited to the Section in March, during the time the patient was under observation—ten years—the tension had not been raised.

DR. G. C. HARLAN called attention to the absence of change in the corneoscleral border as a strong point in favor of the stroma of the iris as the starting-place of the tumor. In speaking of the relief from pain by instillations of eserin, the common practice in glaucoma, he had known duboisia given by mistake in one case of well-marked acute glaucoma completely efficient.

DR. W. F. NORRIS said that it was well known that atropia does not always increase tension.

DR. EDWARD JACKSON reported three cases of

Transient Lesions of the Retina and Choroid from Bruises of the Eyeball,

similar to the case he had reported to the American Ophthalmological Society in 1888. In each case the injury had been severe enough to cause some marking of the lids or eyeball. Impairment of sight was noticed immediately, and examination showed edema of the retina with yellowish rounded spots of choroidal exudation. The haziness of the retina cleared up within 24 or 48 hours. The choroidal spots faded away in from three days to a week, each being followed by an area of redness. In three of the cases that had been observed long enough, recovery was complete. He called attention to the fact that, although the retinal changes had been described by other writers, in these cases the choroidal lesions were quite as marked and more permanent; and that the choroidal changes were distributed in the arc of a circle or circles, having the center at the optic nerve entrance. In only one of these cases was retinal hemorrhage detected.

DISCUSSION.

DR. G. C. HARLAN remembered the first case referred to by Dr. Jackson, and was inclined to believe, from the ophthalmoscopic appearances, that there were minute ruptures of the choroid.

DR. EDWARD JACKSON spoke of the method of

Preserving Ophthalmic Specimens

in formalin solutions, recently published by Mr. Priestly Smith, and showed specimens so mounted. The advantages of the method are the great ease with which the specimens may be permanently preserved in the best condition for inspection, and the fact that it is always available for microscopic examination.

PERISCOPE.

NEWS AND MISCELLANY.

The regular meeting of the Section on Pathology of the Buffalo Academy of Medicine was held May 18. Program: "Brain of a Suicide, with Fissural Peculiarities," Prof. Burt Green Wilder, of Cornell University. Exhibition of Specimens: Mycosis Fungoides, by Dr. G. W. Wende; Gall-stones, etc., by Dr. A. L. Benedict.

Dr. Reineboth, of Halle, according to the Berlin correspondent of the *Medical Press and Circular*, reports the case of a man who, in consequence of a sarcoma threatening suffocation had tracheotomy performed and a canula inserted. He got tired of life, however, and put an end to it by hanging, placing the strangulating cord above the canula so that respiration would still go on unimpeded. Death appeared to have taken place rapidly. The case shows that death by hanging is not brought about by preventing respiration, but by pressure on the large vessels. The position of the body also was such that with continued consciousness the man had not time to get on his feet again. It appears from this that loss of consciousness was as rapid as in ordinary hanging. The autopsy showed anemia of the cerebrum, extreme fulness of the arteries of the base, slighter fulness of those of the pia mater, hyperemia of the pons and medulla. Death by hanging without closure of the air-passages is not unknown in literature, but it would be difficult to find a parallel to the above.—*Bost. Med. and Surg. Jour.*

Ferratin an Official Drug.—The *Chemiker Zeitung*, ——— 31, 1897, states that the Committee now revising the Russian Pharmacopeia for a fifth edition has recommended Ferratin, Menthol, Saccharin, and a few other new remedies for official place. This is quick recognition for Ferratin, and a compliment to its discoverer, Prof. O. Schmiedeberg, the eminent Pharmocologist, of Strassburg University.

The public has begun to realize that vast strides have been made in the practice of medicine and surgery during the past decade, and that **the physician who is best able to cope with disease** is he who has kept in the front rank of medical progress, says *The Medical Fortnightly*. This recognition from the public has had its effect upon the profession, for many of the "contented-with-my-own-knowledge" physicians have found it necessary to "brush up," to pay more attention to recent progress in medicine, and less to the cut of their beards, more to familiarity with medical books and journals, and less with the town-meeting and court-house ring. This has been brought about by the fact that their competitors are young men, who know that accurate knowledge is of more practical service in fighting disease than the wisest looks and solemn silence of the would-be leader in medicine. The result is, the young man is doing his duty and winning his way; he, too, is aware that he cannot hold what he wins unless he maintains his position among the student-physicians, the workers who are always alert and appreciate things new, which are of value to them in accomplishing the one great object, that of saving life and relieving distress.

Capital Operations Without Anesthesia.—In a paper read by Dr. J. J. Buchanan, surgeon to the Pennsylvania Railway Company, at the meeting of the National Association of Railway Surgeons, in St. Louis, the following conclusions are presented: 1. Patients with limbs so crushed as to require amputation, who are in good general condition, should be operated on at once. 2. Those who present evidences of severe shock and great loss of blood, should be treated by external heat and stimulants, including the hypodermatic use of whiskey, digitalin, strychnine and nitroglycerin, and the rectal injection of whiskey, strong coffee and hot water. The crushed limb should be disinfected as completely as possible, and six per thousand saline solution of not less than two quarts for an adult be allowed to flow into a vein, this infusion to be repeated, if necessary, at intervals of a few hours, according to the effect produced. 3. If by these efforts complete reaction should be established, anesthesia and amputation should be proceeded with as in ordinary cases. 4. If, however, a moderate or doubtful reaction only should occur, the propriety of a rapid amputation without anesthesia should be seriously considered, if the consent of the patient be gained. 5. The complete disinfection of crushed, lacerated, dirty and infected limbs usually cannot be accomplished. 6. The sooner such limbs are removed, the better, provided the patient's life be not lost in the operation. 7. If, notwithstanding the vigorous treatment just mentioned, an amputation, either with or without anesthesia, be fraught with great risk, it is far better to disinfect as thoroughly as possible, drain well, pack all open spaces, and take the chance of infection, which, in most doubtful cases, is probably less than the risk of death from shock following operation.

Rejections for Life Insurance.—Dr. John Homans, medical director of the New England Mutual Life Insurance Co., Boston, Mass., says: The presence of the following diseases and conditions in any person applying for insurance will cause the rejection of the applicant unless the applicant presents himself for an examination by the medical director at the home office in Boston:

1. Albumen in the urine; asthma, except rose cold or hay fever; caries, or necrosis of bone; chronic ulcers; cough, frequent or habitual; delirium tremens at any time; diarrhea, present or chronic; discharge from ear; enlarged glands; enlarged veins (varicose) above the knee; epilepsy; fistula, hernia, unless reducible and a suitable truss is worn; insanity; intermittent pulse; opium, chloral or cocaine habit; paralysis; prostate gland disease; pulse below 50 or over 90, stricture, and sugar in the urine.

2. Light Weight.—Persons 15 per cent. under weight, who have lost relatives from consumption, and all persons who are 25 per cent. under weight.

3. Heavy Weight.—Persons 25 per cent. over weight, who have lost relatives from apoplexy or heart disease, and all persons who are 40 per cent. over weight.

4. Consumption in the Family.—1. Where more than three cases have occurred. 2. Where the applicant is under 20, and one case has occurred. 3. Where under 30, and one parent has had consumption. 4. Where under 35, and any two members have shown the disease. 5. Where under 50, and both parents have had the disease.

5. Repeated attacks of renal or hepatic colic and the passage of gall-stone within five years, or a renal or vesical calculus within three years.

Of the different **methods of staining flagella** which have, at different times, been described, Van Ermengen's, in my experience, gives excellent results, but takes too long to accomplish; while Loeffler s, as well as Nicolle and Morax's modification of the same is very uncertain. Pittfield's method gives good results, and is quickly accomplished, but the flagella are, as a rule, very faintly stained. The method which is now commonly adopted in this laboratory (David McCrorie, Glasgow Royal Infirmary, *British Medical Journal*) is somewhat similar to Pittfield's, but we use a different stain, and invariably we get both bacilli and flagella more

distinctly stained than by Pittfield's method. The dye we use is an aniline blue which is known commercially as "Night Blue," from the fact that it shows as well in artificial as it does in sunlight. The formula which we find to give the best results is:

10 c.cm. of a concentrated alcoholic solution of "night blue."
+10 c.cm. of a 10 per cent. solution of alum.
+10 c.cm. of a 10 per cent. solution of tannic acid.

The addition of 0.1 to 0.2 g. of gallic acid would seem to add to the value of the mordant stain, but excellent results can be obtained without this addition.

The method we adopt is this: A drop of sterilized water is placed on an absolutely clean coverglass, held in a Cornet's clip, and carefully inoculated with the smallest particle of a twenty-four hours' agar culture. The coverglass is moved in such a way that the drop of water is distributed over nearly its whole surface, or a suspension may be made in a watchglass, and a thin film spread upon a coverglass. It is then placed in the incubator until thoroughly dried (two minutes). A small quantity of the mordant stain is then poured on, and the coverglass again placed in the incubator for two minutes, or held for that time two feet above the flame of a Bunsen burner. The excess of stain is now washed off by running water, the coverglass dried in the incubator, and then mounted in Canada balsam. The mordant stain can be used either filtered or unfiltered; it does not necessarily require to be made fresh each time, as we find that the stain is quite as efficient after a fortnight or so as on the first day of use. The whole process can be accomplished in a few minutes.

J. Bland Sutton, in a paper read before the Medical Society of London and reported in the *Brit. Med. Jour.* (January 16, 1897) states that **the epithet "wandering" has been applied to organs unduly mobile**, the common examples being wandering kidney and a wandering goiter; in none is the term so well deserved as in the case of a very movable spleen. The positions assumed by a wandering spleen are very dissimilar; moreover, wandering spleens exhibit more undue mobility than a similar condition of the kidney. Wandering spleens are almost, but not exclusively, confined to women, and in the majority of cases the subjects have had children. A wandering spleen may, and occasionally does, jeopardize life. The dangers are:

(1.) Rupture of stomach or duodenum.
(2.) Intestinal obstruction.
(3.) Abscess of spleen.
(4.) Rupture of spleen.

Wandering spleens have been confounded with many kinds of abdominal tumors, such as ovarian cysts, renal tumors, malignant tumors of the omentum, movable kidneys, and uterine myomata. Splenectomy for wandering spleen is not only justifiable, but it is a highly successful operation, the rate of recovery being equal to that of ovariotomy in skilled hands. The great difference between splenectomy and splenopexy is that, in the former case, the individual is deprived of an organ, and, although we do not know with any degree of precision what its real use is, we are nevertheless bound to display caution in dealing with it. The writer regards the spleen as a highly developed and specialized lymph gland, and at present there seems to be no reason for hesitating to remove it when "wandering" and troublesome, in so far as remote consequences are concerned, than excising a crowd of enlarged glandulæ concatenatæ. It is a fact that many, if not all, individuals with a wandering spleen are very thin and often gaunt, and, so far as the author's observations go, they retain this character when spleenless.

At the initial meeting of the **American Gastro-enterological Association** to be held at Philadelphia June 3, 1897, the following papers are to be read: The Limitations of Our Specialty, A. L. Benedict, Buffalo; (*a*) The Diagnosis of Gastric Carcinoma, (*b*) The Cause of the Digestion and Absorption of Rectal Nutritive Enemas, J. C. Hemmeter, Baltimore; The Chemistry of Foods and their Relation to the Chemistry of Digestion, A. P. Buchman, Fort Wayne, Ind.; Further remarks on Erosions of the Stomach, Max Einhorn, New York; Clinical Histories, (*a*) Impacted Gall-stone Simulating Cancer of the Pylorus, (*b*) Cancer of the Colon (near Sigmoid Flexure), Henry L. Elsner, Syracuse, N. Y.; Stomach Washing in Infancy and Childhood, Henry E. Tuley, Louisville, Ky.; The Relation of HCl Secretion to Indicanuria, Allen A. Jones, Buffalo; Atrophy of Stomach, with exhibition of specimen, Julius Friedenwald, Baltimore; Some Indications and Contra-indications for the Employment of Abdominal Massage in Diseases of the Stomach and Intestines, Boardman Reed, Philadelphia; Gastro-Enteritis Infantum, H. Beck, New York; Gastric Disturbances Caused by Hernia of Linea Alba in the Epigastrium, Charles D. Aaron, Detroit, Mich. The meeting will be called to order at 2.30 P.M., at the College of Physicians and Surgeons, corner Thirteenth and Locust streets.

Dr. Chauffard says that powdered sugar covered thickly over **chronic ulcers of the leg** and retained by usual dressing is a successful mode of treatment. The sugar is first applied daily, then every other day, and later at longer intervals, until complete cicatrization has been effected.—*Atlanta Med. and Surg. Journal.*

When a physician is called upon to attend a patient afflicted with a **carbuncle, during the incipient stage**, it is well to recollect that the claim is made that a six per cent. solution of cocain, consisting of ten drops, injected into the carbuncle hypodermatically will allay the inflammation at once, and promptly cure the case.—*Med. Arena.*